

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 02497 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 45 6:45 AM				
Charles Walter Allen						1-22-80							
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH 6 DAY 16 YEAR 1924			6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Rhode Island		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Talbot			MD.			
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor			12b. KIND OF BUSINESS OR INDUSTRY Telephone Co.						
13a. STATE Md		13b. COUNTY Dorchester		13c. CITY OR TOWN Rhodesdale			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Route 1 Box 40				
14. FATHER'S NAME Charles Congdon Allen		15. MOTHER'S MAIDEN NAME Agnes								LAST Hunter			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO WW II 549 24 2770			17. INFORMANT Elizabeth V. Allen			ADDRESS Same as #13 (Wife)					
18. CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes Mellitus</u>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8</u> to <u>19:45</u> on <u>1/22</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>1/21</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>William J. Banfield</u>		22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 1/22/80					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) William J. Banfield		22f. ADDRESS Easton, Maryland											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/25/80			23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery			23d. LOCATION CITY OR TOWN Brentwood			COUNTY P.G. STATE Md.		
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland								25a. DATE REC'D. BY REGISTRAR JAN 25 1980		25b. REGISTRAR'S SIGNATURE Hector McCreedy			
DHMH-16 25M (VRA 15, 4) 1/79													

10

1000 1000

B2.8.1.1.2.1.1

Oxford University

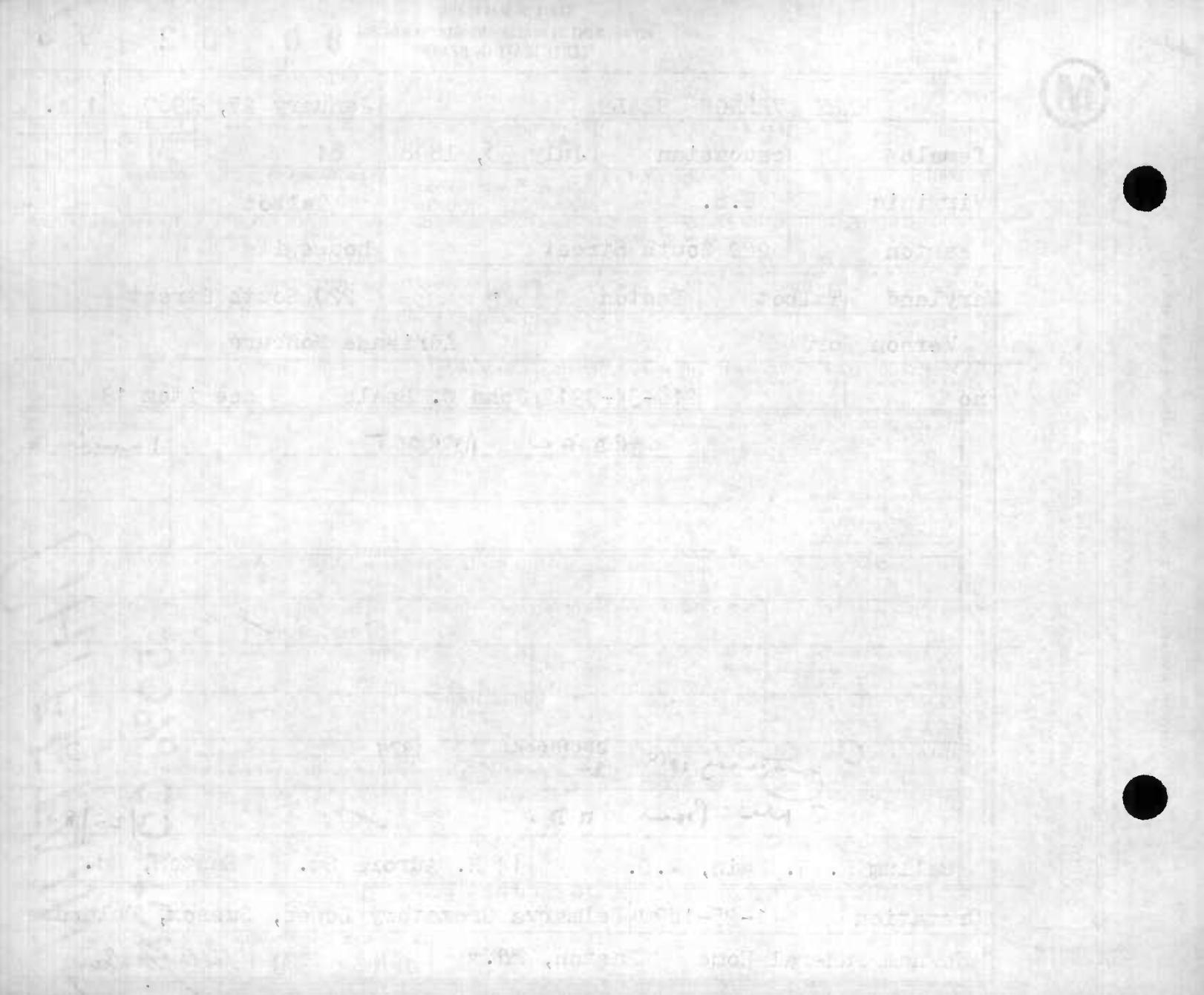
with help of a computer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8002498	REG. NO.				
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)				MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
			MARY VERNON BEALE								January 25, 1980					1 A. M.	
3 SEX			4 RACE			5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
female			caucasian			MONTH July 30, 1898 YEAR			81			MONTHS		DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Virginia			U.S.			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Talbot								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Easton			220 South Street			housewife											
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS							
Maryland			Talbot		Easton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			220 South Street							
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST		
Vernon Ford									Adrienne Moncure								
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
no			218-34-9912			John C. Beale			see item 13			Immediate					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4275 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22a. I certify that <input checked="" type="checkbox"/> (I) this hospital attended the deceased from <u>December 19 1979</u> to <u>19</u> , to <u>19</u> , that <input checked="" type="checkbox"/> (I) (we) last saw the deceased alive on <u>January 18 1980</u> <u>8:30</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE C. R. Bain			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1/25/80								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS														
Callum R. W. Bain, M.D.			14 N. Aurora St.						Easton, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 1-25-1890			23c. NAME OF CEMETERY OR CREMATORIAL Delmarva Crematory			23d. LOCATION CITY OR TOWN Lewes, Sussex, Delaware			COUNTY		STATE			
24. FUNERAL DIRECTOR Newham Funeral Home			ADDRESS Easton, Md.			25a. DATE REC'D. BY REGISTRAR JAN 28 1980			25b. REGISTRAR'S SIGNATURE Patsy McCready								

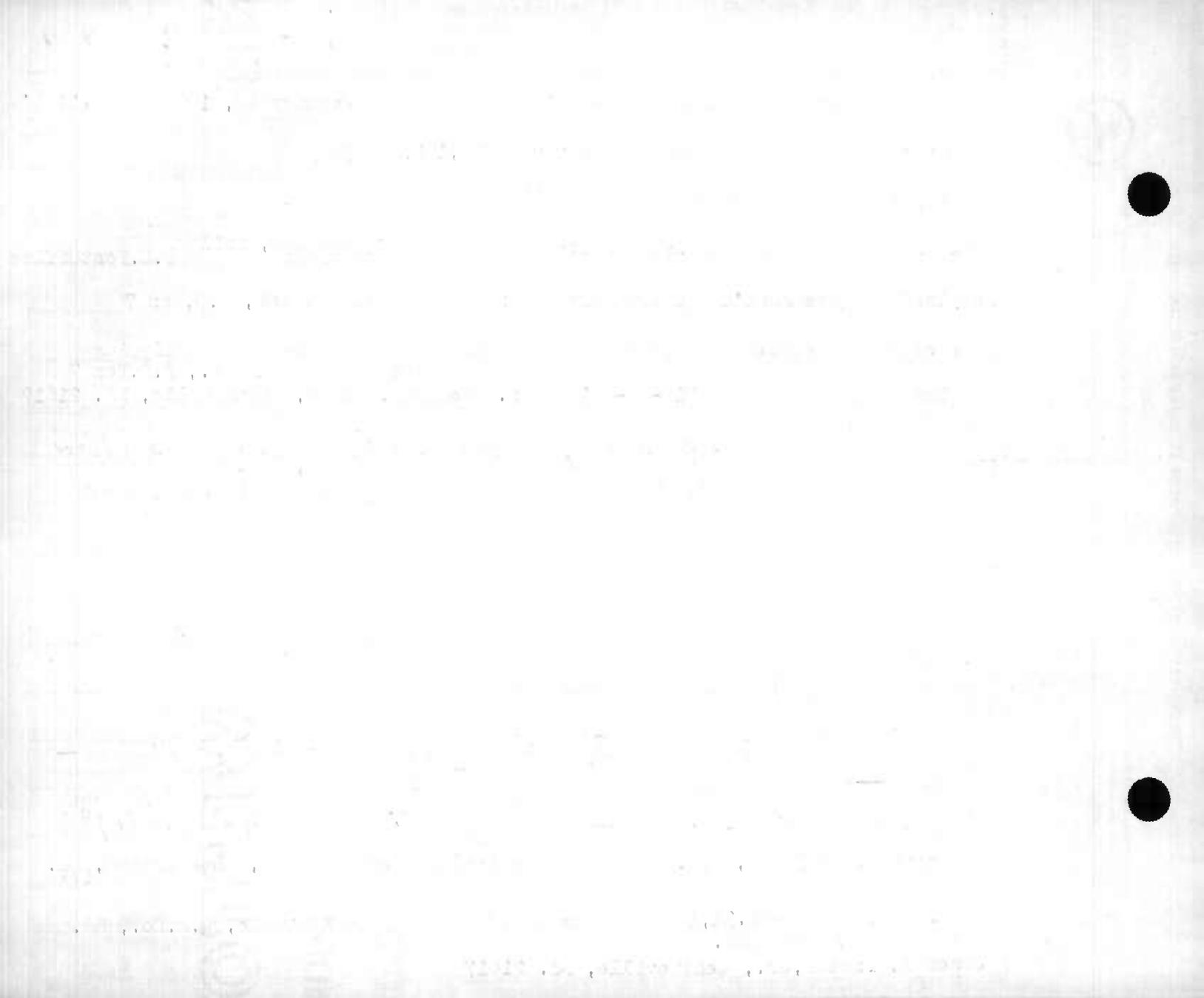


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death, and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8002499	REG. NO.												
1 - FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)						FIRST Oliver			MIDDLE Allen		LAST BERRY			2a. DATE OF DEATH MONTH January 28, 1980			DAY YEAR			2b. HOUR 9:27 P.M.		
3. SEX Male			4 RACE White			5 DATE OF BIRTH MONTH September 26, 1920			6 AGE (IN YEARS LAST BIRTHDAY) 59 YRS			7 IF UNDER 1 YEAR MONTHS DAYS			8 IF UNDER 24 HRS HOURS MIN										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Talbot			10 CITY OR TOWN OF DEATH Easton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Memorial Hospital			12a. USUAL OCCUPATION Supervisor, Mail services			12b. KIND OF BUSINESS OR INDUSTRY U.S. PostOffice				
13a. STATE Maryland			13b. COUNTY QueenAnne's			13c. CITY OR TOWN Centreville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Elm Street, P.O. Box 7													
14. FATHER'S NAME FIRST Joseph			MIDDLE Kenneth			LAST Berry			15. MOTHER'S MAIDEN NAME FIRST Ann			MIDDLE Wray			LAST Tipping										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. IF YES, GIVE WAR OR DATES WW II			16c. SOCIAL SECURITY NO 218-05-0428			17. INFORMANT Wife			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden			ADDRESS Elm St., P.O. Box 7										
18. CAUSE OF DEATH (Enter only one cause per line for 18, 19, and 20.) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF: (b) Arteriosclerotic coronary artery disease years																						
410- Conditions, if any, which gave rise to immediate cause 18, stating the underlying cause, if any			DUE TO, OR AS A CONSEQUENCE OF: (c)																						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 18.																									
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE										
22a. I certify that (I) (his hospital) attended the deceased from 31/28/1977 to 12/15/1979, that (I) (did not) last saw the deceased alive on 12/15/1979, and that in (my) (his) opinion death occurred on the date and hour and from the causes stated above, (I) (did not) (did not) view the body after death.																									
22b. SIGNATURE Wayne D. Benjamin			DEGREE												22c. DATE SIGNED 1/31/80										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wayne D. Benjamin, M.D.			22e. ADDRESS Medical Office Building, Chestertown, Md. 21620																						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan. 31, 1980			23c. NAME OF CEMETERY OR CREMATORIAL Chesterfield			23d. LOCATION CITY OR TOWN Centreville, Queen Anne's Co., Md.			CITY OR TOWN CENTREVILLE, QUEEN ANNE'S CO., MD.			COUNTY			STATE							
24. FUNERAL DIRECTOR NAME James H. Barton, Jr., Centreville, Md. 21617			ADDRESS			25a. DATE REC'D. BY REGISTRAR FFB A 7 1980			25b. REGISTRAR'S SIGNATURE L. Barton, Jr., Esq.																



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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8002500								
												REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Charles Heney Beulah												Jan 17 80						5:05 AM		
3 SEX		4 RACE		5 DATE OF BIRTH						6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
Male		Negro		Month			Day			62			MONTHS	DAYS	HOURS	MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED			NEVER MARRIED			9 BALTIMORE CITY OR COUNTY OF DEATH										
Federalsburg, Md.		U.S.A.		<input checked="" type="checkbox"/>			<input type="checkbox"/>			Talbot										
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY													
Easton		Memorial Hospital		Farmer			Farming													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS										
Maryland		Caroline		Federalsburg			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1002 Federalsburg Gardens										
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME																		
Emory Dickerson		Ida B. Jackson																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT			18. ADDRESS													
No		213-22-8424DI		Mrs. Ida Hammond, Old Denton Rd., Federals-			burg, Maryland 21632													
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
5711 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												Hepatitis + pneumonia Alcoholism								
DUE TO, OR AS A CONSEQUENCE OF (b)												wks								
DUE TO, OR AS A CONSEQUENCE OF (c)																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.																				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1/16 1980 to 1/17 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.												22b. DATE SIGNED								
22c. SIGNATURE		22d. DEGREE		22e. ATTENDING PHYSICIAN <input type="checkbox"/>			22f. MEDICAL DIRECTOR <input type="checkbox"/>			22g. STAFF PHYSICIAN <input type="checkbox"/>			22h. DATE SIGNED							
22i. PHYSICIAN'S NAME (TYPE OR PRINT)		22j. ADDRESS																		
Burial		Jan. 21, 1980		Federal Hill Cemetery, Federalsburg			City or Town			County			State							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. DATE REC'D. BY REGISTRAR			23f. REGISTRAR'S SIGNATURE							
Burial		Jan. 21, 1980		Federal Hill Cemetery, Federalsburg			City or Town			County			State							
24. FUNERAL DIRECTOR NAME		ADDRESS																		
Michael F. Eubank		Fromington - Womkins Box 43 Federalsburg																		
DHMH-16 25M (VRA 15, 4) 1/79																				

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retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Item 3 should be detached for use as the burial-triptych. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the time of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 02501	REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Noah W. Blunt			Blunt			January 6 1980			70	YRS	5A M	5A M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		Cau.		Month 1-29-09 Day Year			70			MONTHS	DAYS	HOURS	MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Md.		U.S.A.		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Talbot			Farming				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN A HOSPITAL, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
EASTON			Memorial Hospital						Farmer			Farming		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
Md.		Caroline		Greensboro		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Hill Rd.					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
Noah W. Blunt			Mary Quillen											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
no			215-18-4974			Buelah M. Blunt			Greensboro, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										Years				
515- Diffuse Pulmonary Fibrosis										Years				
DUE TO, OR AS A CONSEQUENCE OF (b) Diffuse Alveolitis										Years				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (We) attended the deceased from saw the deceased alive on 1/15 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.										1/22 1980, to 1/6 1980				
22b. SIGNATURE Buelah										DEGREE MD	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 1/6/80
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 14 N. Aurora St. Easton, Md 21601											
P.G. Rhodes														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 1-8-80			23c. NAME OF CEMETERY OR CREMATORIAL Chesterfield			23d. LOCATION CITY OR TOWN Centreville			COUNTY Q.A. Md.	STATE	
Burial														
24. FUNERAL DIRECTOR NAME John S. Boulders			ADDRESS Greensboro			25a. DATE REC'D. BY REGISTRAR JAN 10 1980			25b. REGISTRAR'S SIGNATURE John S. Boulders					

30

1-30-80

Can

line

x

total

number

total

unit

x

category

DN

max utilization

max. time

512-18-1934 Project N binary crossover

no

start binary 2 9/11
end binary 2 9/11

02. 11

02. 21/11

11/18

18

20/11/80

11/18 1980 12 hours 14 m

11/18 1980 12 hours 14 m

category

category

00-0-1

initial

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 02502							
										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR								
Anna J. Brown						Jan. 11 1980			9 AM								
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS AND BIRTHDAY)			IF UNDER 1 YEAR		# UNDER 24 HRS					
FEMALE		WHITE		MARCH 20, 1909			70 YRS			MONTHS	DAYS	HOURS	MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
MARYLAND		U.S.A.						79/60t									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Easton		Memorial Hospital								Housewife			House work				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS								
MD.		CAROLINE		GOLDSBORO					R.D.1 BOX 278								
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								ADDRESS							
Joseph ALDA JACKSON		MYRA CAROLYN WILEY								R.D.1 BOX 278 JOHN H. BROWN, SR. GOLDSBORO, MD, 21636							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 16b. SOCIAL SECURITY NO.										17. INFORMANT				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
NO — 213-18-4767										JOHN H. BROWN, SR. GOLDSBORO, MD, 21636							
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiac arrest</u>																	
4275 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost																	
DUE TO, OR AS A CONSEQUENCE OF (b)																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from saw the deceased alive on 1/11 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.										1/11/80 19 10 00				1/11		19 80	
22b. SIGNATURE James Gieske, M.D.										DEGREE				22c. DATE SIGNED 1/11/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>							
James Gieske, M.D.										22e. ADDRESS 108 N. Wash. St. Easton, Md. 21601							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 1-13-80			23c. NAME OF CEMETERY OR CREMATORIAL Hollywood Cemetery			23d. LOCATION CITY OR TOWN HARRINGTON			COUNTY Kent		STATE Del.			
24. FUNERAL DIRECTOR NAME <u>James P. McKnatt</u>			ADDRESS <u>Commerce St.</u>			25a. DATE RECD. BY REGISTRAR JAN 17 1980			25b. REGISTRAR'S SIGNATURE <u>Henry McKnatt</u>								
McKnatt Funeral Home Harrington, Del.																	

100 K. Map. 55. 510

James C. Giese, M.D.

1-12-80 Hospital Center, New Haven, Conn.
1980, May 1, 1980, New Haven, Conn.

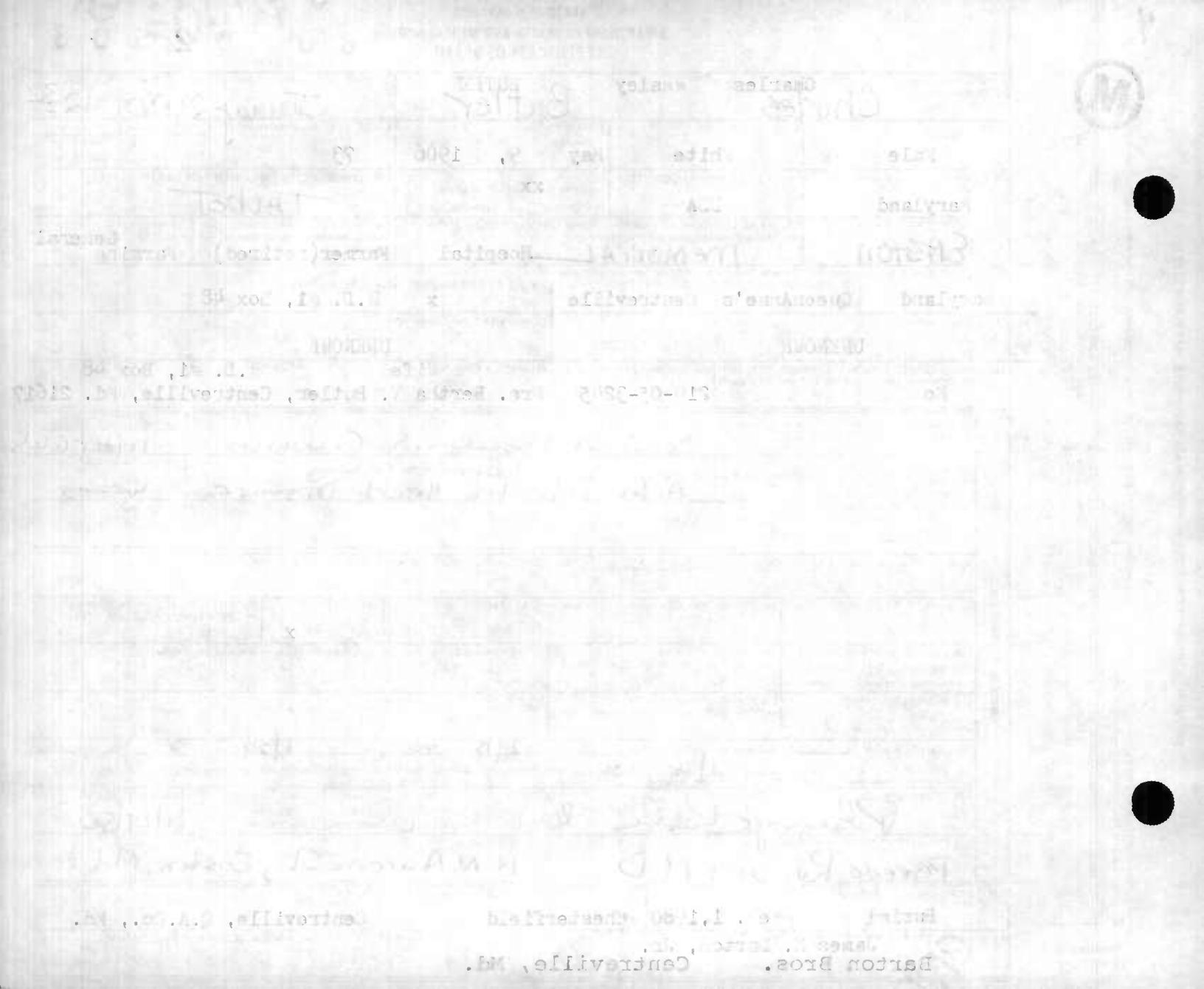
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8002503	REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST Charles MIDDLE Wesley LAST BUTLER			2. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Charles		Charles			Butler			January 29, 1980			12:30 AM	
3. SEX		4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7b. HOUR	
Male		White			Month May Day 9, Year 1906			73			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD. Talbot	
Maryland		USA										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			General Farming	
Easton		Memorial Hospital			Farmer (retired)							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
Maryland		Queen Anne's		Centreville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		R.D. #1, Box 48				
14. FATHER'S NAME		FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME							
		UNKNOWN			UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
No		219-05-3245			Wife			R.D. #1, Box 48			12:30 AM	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			Mrs. Bertha V. Butler, Centreville, Md. 21617									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Cerebral Vascular Occlusion - 4140 (Bilateral arteries)									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			Arteriosclerotic Heart Disease									
(b)			Years									
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/18/1980 to 1/29/1980, that (I) (we) last saw the deceased alive on 1/28/1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE P. Gregor Rhodey M.D.												
22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 1/29/80							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 14 N. Aurora St., Easton, Md. 21601										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Feb. 1, 1980			23c. NAME OF CEMETERY OR CREMATORIAL Chesterfield			23d. LOCATION CITY OR TOWN Centreville, Q.A.Co., Md.			COUNTY STATE	
24. FUNERAL DIRECTOR NAME Barton Bros.		James H. Barton, Jr. Barton Bros.			25a. DATE REC'D. BY REGISTRAR FEB 07 1980			25b. REGISTRAR'S SIGNATURE Henry McCloskey				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 02504						
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Pearl Carpenter									Carpenter			Jan. 24 1980				1980	2 PM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		8. IF UNDER 1 HR MONTHS DAYS HOURS MIN						
Female		Negro		7 7 81			58											
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH CITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Md		Easton		Memorial Hospital			Domestic											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS								
Md		8a		Greentown			YES <input type="checkbox"/> NO <input type="checkbox"/>			Bt-1 Box 312								
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST			
Freddie						Flamer			Woloda			Miller						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
NO			215-18-4307			William Carpenter			85									
18. CAUSE OF DEATH (Enter only one cause per line for 1(a), 1(b), and 1(c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												410 - Acute Myocardial Infarction						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												DUE TO, OR AS A CONSEQUENCE OF 1b) (a) (b) (c)						
DUE TO, OR AS A CONSEQUENCE OF 1b) (a) (b) (c)												year						
DUE TO, OR AS A CONSEQUENCE OF 1c)																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE WORK <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1/22 1980 to 1/24 1980, that (I) (we) last saw the deceased alive on 1/22 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED						
Wm. W. Wood						MD						1/25/80						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			EASTON MD												
Wm. W. Wood																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE				
1/28/80			1/28/80			Carmichael Cem.			Carmichael			8A		MD				
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
John H. Clark			Eaton, MD			FEB 6 1980			John H. Clark									

BP _____

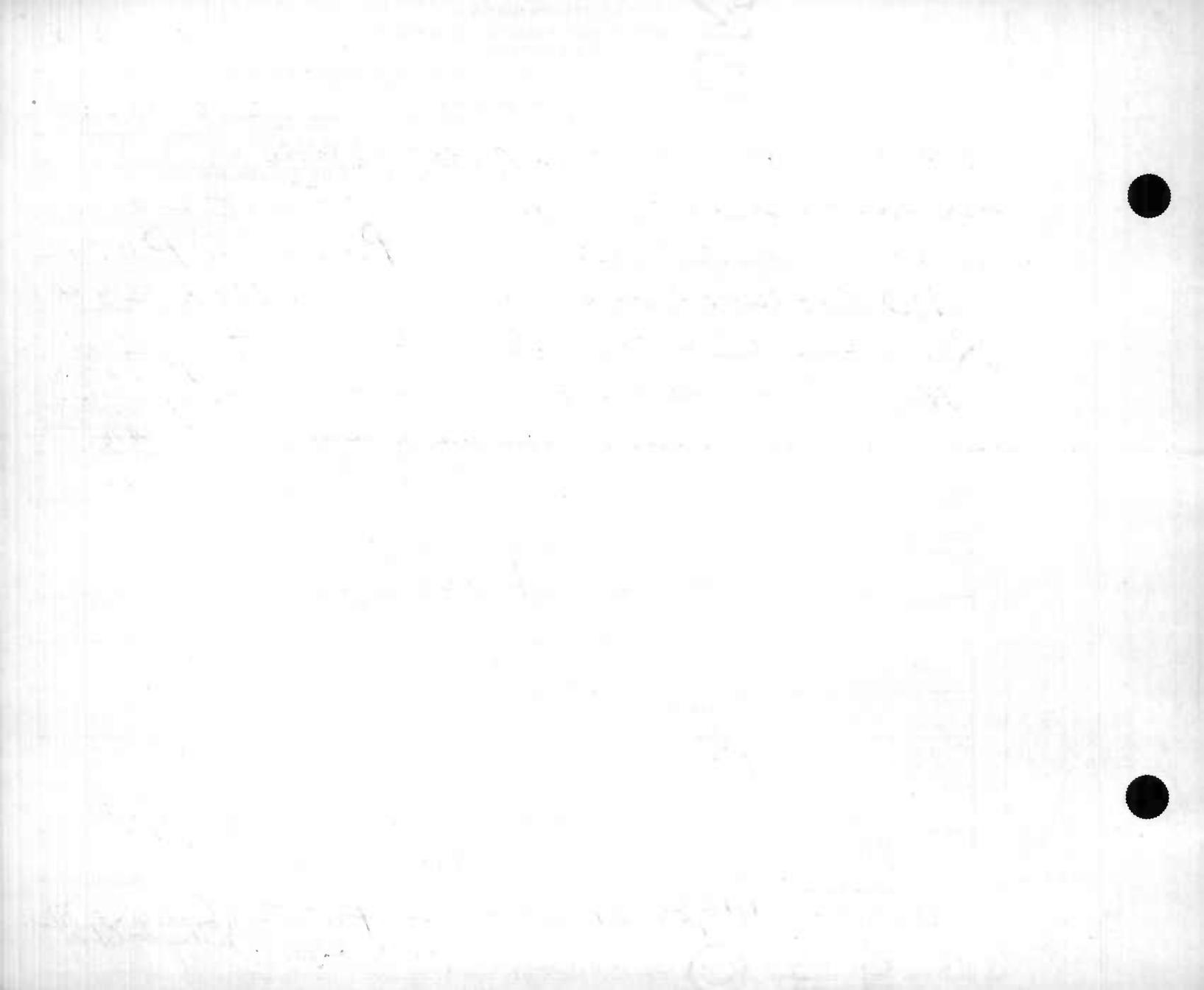
size 281 1.5N
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TO HOSPITALS ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 02505	REG. NO.				
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR					
VELMA C. CHRISTOPHER									1 8 80			10:20 P.M.					
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH MONTH DAY YEAR MARCH 5, 1889			6. AGE (IN YEARS LAST BIRTHDAY) 90 YEARS YRS			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CAROLINE Co.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY OR COUNTY OF DEATH 12 B-5 Co., MD.								
10. CITY OR TOWN OF DEATH EASTON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOUSE IN THE PINES			12. USUAL OCCUPATION POSTMISTRESS			13. KIND OF BUSINESS OR INDUSTRY POSTAL								
13a. STATE MD.			13b. COUNTY CAROLINE			13c. CITY OR TOWN PRESTON			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Box 284					
14. FATHER'S NAME FIRST MIDDLE LAST Roswell C. ARROLL			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH ANDREW			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 218-12-1044			17. INFORMANT ADDRESS MRS. LOUISE CHRISTOPHER, MD.					
18. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR 18, 1b, AND 1c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (1a) 4414			18b. DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arthiosclerosis 18c. DUE TO, OR AS A CONSEQUENCE OF (c)			18d. APPROXIMATE MATERIAL BETWEEN DEATH AND DEATH 98 hr											
19. MEDICAL CERTIFICATION			20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Abnormal Aorta Aneurysm			21. DATE OF OPERATION			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20d. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20f. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 11/3 1980			21e. LOCATION STREET 1991			21f. CITY OR TOWN 118		
21g. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21h. CITY OR TOWN COUNTY STATE			21i. LOCATION STREET CITY OR TOWN COUNTY STATE			21j. DATE SIGNED 1/9/80								
22a. I certify that (1) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (1) (we) lost saw the deceased alive on 11/3 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.			22b. SIGNATURE Wm (W) Wood Jr.			22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Wm H Wood Jr.			22f. ADDRESS EASTON, MD.			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 1/12/80			23c. NAME OF CEMETERY OR CREMATORIAL JR. ORDER Cem			23d. LOCATION CITY OR TOWN COUNTY STATE PRESTON, CAROLINE, MD.		
24. FUNERAL DIRECTOR NAME FRANKLIN - HAWKINS			24b. ADDRESS Box 43 Federalsburg			25a. DATE REC'D. BY REGISTRAR 1AN 1 6 1980			25b. REGISTRAR'S SIGNATURE Hawkins								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-travel permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 301 W. Preston St., Baltimore, Maryland 21201.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8002506					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
Lewis W.			Copper			January 27 1980			545 PM						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7a. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		7b. IF UNDER 24 HRS MONTHS DAYS HOURS MIN			
Male		Negro		9 20 1882			97 YRS								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Md.		US					Talbot								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					
Eaton		the Memorial Hospital								Retired					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS					
Md.		Talbot		Eaton						127 Locust St.					
14. FATHER'S NAME		FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO			17. INFORMANT				
Charles		Charles Copper			Mrs Charles Copper			220-05-1294A			Mrs Maple Copper 127 Locust St.				
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE WAR OR DATES		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
NO														1-22-80	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Bronchopneumonia													
485		DUE TO, OR AS A CONSEQUENCE OF (b)													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
Generalized arteriosclerosis															
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. LOCATION STREET CITY OR TOWN COUNTY STATE			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (1) (this hospital) attended the deceased from 2-9 1976 to 1-27 1980, that (1) (we) last saw the deceased alive on 1-27 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.															
22b. SIGNATURE		DEGREE												22c. DATE SIGNED	
Robert W. Trever, M.D.														1-28-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS													
Robert W. Trever, M.D.		RD 3 Eaton Md. 21601													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY		23f. STATE			
Burial		2/2/80		Richards			Eaton								
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Dashiel Funeral Hn.		P.O. Box 606 Eaton MD		FEB 6 1980						Randy Kennedy					

BP

0.7 over 7.5 sec

0.87 0.671

TO HOSPITAL OR ATTENDING PHYSICIAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transcript. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8002507		
										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 30			
Virginia H. Craft			JANUARY 4 1980			71			2 P.M.			
3. SEX Female			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR Nov. 23, 1908			6. AGE IN YEARS (LAST BIRTHDAY) 71 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			7c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. BALTIMORE CITY OR COUNTY OF DEATH Talbot			
10. CITY OR TOWN OF DEATH Easton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION The Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland			13b. COUNTY Talbot			13c. CITY OR TOWN Royal Oak			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME William			15. MOTHER'S MAIDEN NAME S. Wrightson			13e. STREET ADDRESS Bellevue Road			13f. ADDRESS P.O. Box 1363 Easton, Maryland			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 218-50-2284			17. INFORMANT Betty D. Sharp			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4039			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Hypertension DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Vascular insufficiency of clavicular 4 days. DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Hypertensive Cardiovascular Disease with Chronic CHF												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 1/1/71 to 1/4/80, that (I) (we) last saw the deceased alive on 1/1/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE W M H Wood			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1/4/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W M H Wood			22e. ADDRESS EASTON, MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-7-80			23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Mem. Park			23d. LOCATION CITY OR TOWN Easton			
24. FUNERAL DIRECTOR NAME Newnam Funeral Home			24a. ADDRESS 200 S. Harrison St. Easton, Maryland			24b. DATE REC'D. BY REGISTRAR JAN 8 1980			24c. REGISTRAR'S SIGNATURE JAN 8 1980			

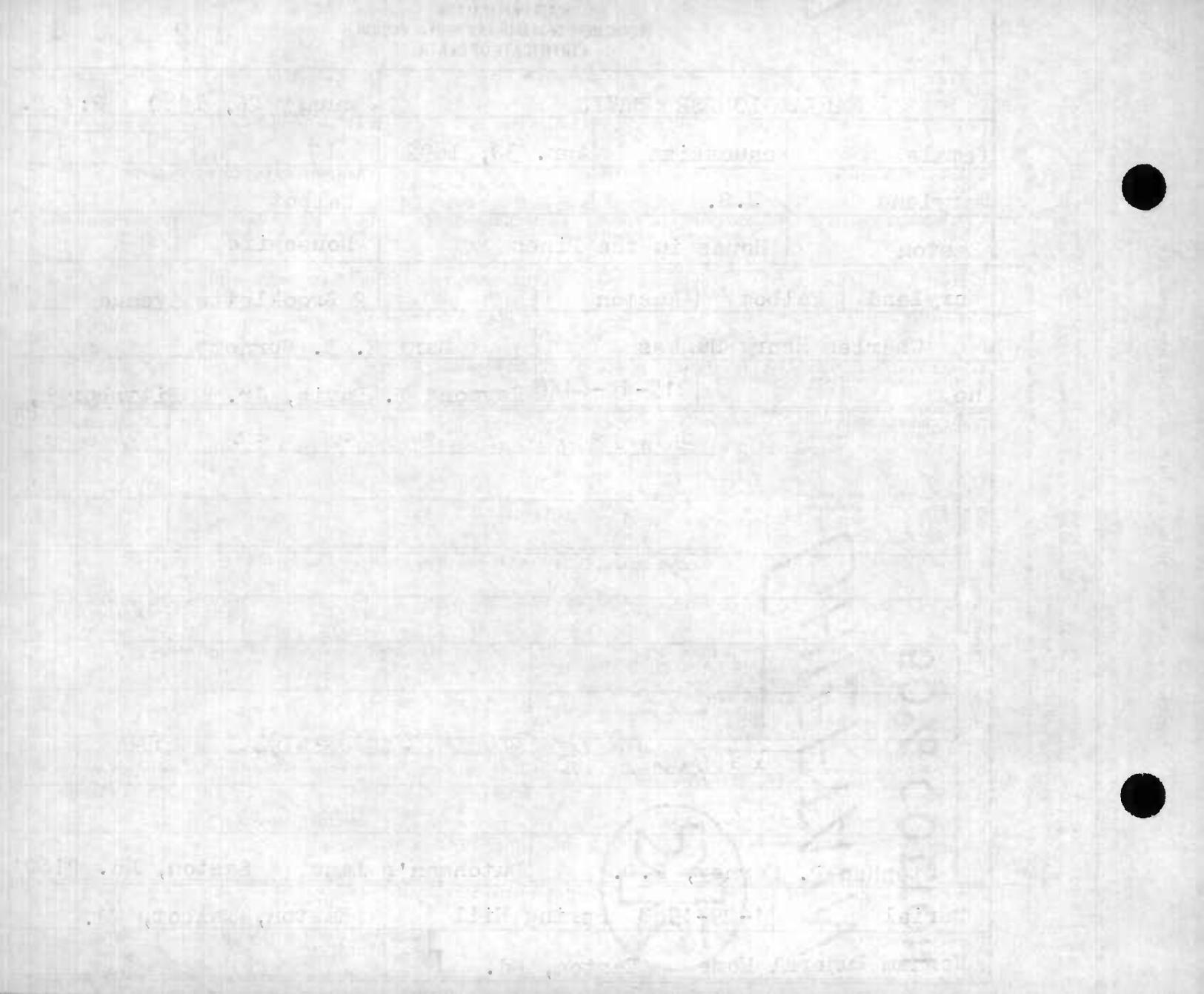
Today I
expressed a slight
indulgence in
certain
delicacies
but do
not intend to do
so again.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80002508											
REG. NO.																							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
MARIA LOUISE DAVIS												January 26, 1980						2:40 P.M.					
3. SEX female			4. RACE caucasian			5. DATE OF BIRTH MONTH DAY YEAR Apr. 30, 1892			6. AGE (IN YEARS LAST BIRTHDAY) 87			7. IF UNDER 1 YEAR YRS.			8. IF UNDER 24 HRS MONTHS DAYS HOURS MIN.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Talbot			10. CITY OR TOWN OF DEATH Easton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) House in the Pines			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Talbot			13c. CITY OR TOWN Easton			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 2 Brookletts Avenue											
14. FATHER'S NAME FIRST MIDDLE LAST Charles Henry Hughes									15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. B. Burnett														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 215-44-6446			17. INFORMANT Raymond T. Davis, Jr.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.			ADDRESS Pittsburgh, PA			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 weeks								
									DUE TO, OR AS A CONSEQUENCE OF (b) A840									MANY yrs					
									DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that (I) (the hospital) attended the deceased from 15 Feb 1965 to 20 Jan 1980, that (I) (we) last saw the deceased alive on 23 Jan 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE Stephen P. Carney, M.D.						DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>			STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED FEB 1 1980					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen P. Carney, M.D.						22e. ADDRESS Dutchman's Lane			23a. NAME OF CEMETERY OR CREMATORIAL SPECIFY Burial			23c. LOCATION CITY OR TOWN CITY OR TOWN Easton, Talbot, Md.			23d. COUNTY Talbot			23e. STATE Md.					
24. FUNERAL DIRECTOR NAME Newnam Funeral Home			ADDRESS Easton, Md.			25a. DATE REC'D. BY REGISTRAR FEB 1 1980			25b. REGISTRAR'S SIGNATURE John J. Carney														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 02509	REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Dorothett Mae</i>			LAST <i>Dawson</i>		20. DATE OF DEATH			MONTH	DAY	YEAR	26. HOUR
3. SEX Female		4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR Jan. 26, 1915		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot</i>			MONTHS		DAYS	
10. CITY OR TOWN OF DEATH <i>EASTON</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN STATE FACILITY, GIVE STREET ADDRESS) <i>THE MEMORIAL Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY					
12a. STATE Md.		13. COUNTY W.H. Co.		13. CITY OR TOWN Chester, Md.		13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13b. STREET ADDRESS None					
14. FATHER'S NAME FIRST <i>William</i>		MIDDLE <i>Herman</i>		LAST <i>Stevens</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Florence</i>			MIDDLE <i>Estelle</i>		LAST <i>Marshall</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 220-34-9314			17. INFORMANT ADDRESS <i>Steve Dawson, Chester, Maryland 21619</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary Failure</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Hours</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Bronchogenic Carcinoma</i>										Months			
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Excessive Obesity</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <i>12/10/80</i> to <i>Present</i> <i>1980</i> that (I) (we) lost saw the deceased alive on <i>1/26/80</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>P. Gregg Rhodes</i>		22c. DEGREE <i>M.D.</i>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>1/26/80</i>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>P. Gregg Rhodes M.D.</i>		22f. ADDRESS <i>14 N. Aurora St, Easton, Md 21601</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>1-29-80</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Woodlawn Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Easton Talbot, Md.</i>							
24. FUNERAL DIRECTOR NAME <i>Helfenbein-Hubbard</i>		ADDRESS <i>Funeral Home Chester, Md.</i>			25a. DATE REC'D. BY REGISTRAR <i>REB 05 1980</i>		25b. REGISTRAR'S SIGNATURE <i>Jeffrey McCready</i>						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be forwarded for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of the death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8002510							
REG. NO.																	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2. DATE OF DEATH MONTH DAY YEAR			2b HOUR								
EARLE			DAWSON, Sr.			January 8 1980			11 55 AM								
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN							
Male		Caucasian		April 7, 1898			81										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. IF UNDER 4 HRS MONTHS DAYS HOURS MIN							
Maryland		U.S.A.					Talbot										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
EASTON		Memorial Hospital		Mechanic													
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Cordova			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS P.O. Box 45							
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST															
Ira		Lydia			Stoker												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT			ADDRESS			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
No		220-32-0727		M. Elizabeth Dawson			P.O. Box 45 Cordova, Md.			10 days							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										Acute Myelogenous Leukemia							
2050 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.										DUE TO, OR AS A CONSEQUENCE OF (b)							
										DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										Chronic Slower atrophy & Renal Failure; Ascites							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IN EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (1) this hospital attended the deceased from <u>1/8/78</u> to <u>1/8/80</u> , and that (2) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Donald T. Lewers, M.D.										DEGREE							
22c. ADDRESS Dutchmans Lane, Easton, Maryland										22d. DATE SIGNED 1/9/80							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE 1-12-80		23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Mem. Park			23d. LOCATION Talbot County Maryland		
24. FUNERAL DIRECTOR NAME Newnam Funeral Home										24a. ADDRESS 200 S. Harrison St Easton, Maryland		24b. DATE REC'D. BY REGISTRAR JAN 14 1980			24c. REGISTRAR'S SIGNATURE F. Newnam		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial and Mental Hygiene permit. Then please remove carbon copy. Item 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8002511	
												REG. NO.	
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			Martha L.			Dix			JANUARY 16 1980			3 A.M.	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE IN YEARS LAST BIRTHDAY			IF UNDER 1 YEAR	
Female			Cau.			4-5-18			61			MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Washington D.C.			U.S.A.						Towson				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
EASTON			Memorial Hospital			Housewife			None				
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
Md.			Caroline						N. Main St.				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
Charles Detmer			Claudia Graham										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
NO			577-09-7753			Charlene Corder			Ridgely, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Streptococcal pneumonia</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____							
22a. I certify that (I) (this hospital) attended the deceased from <u>1/16</u> , 19 <u>80</u> , to <u>1/17</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Charlene Corder MD</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>1/16/80</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 1-21-80			23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill			23d. LOCATION CITY OR TOWN Washington D.C.				
24. FUNERAL DIRECTOR NAME <u>John E. Beale, Greenlawn, Md.</u>			ADDRESS			25a. DATE REC'D. BY REGISTRAR JAN 21 1980			25b. REGISTRAR'S SIGNATURE <u>Henry McCreedy</u>				

BP _____

DHMH-16 25M
(VRA 15, 4) 1/79

08-15-1

10136030

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3 RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION OR REMOVAL.

1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 02512					
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE		LAST			2a. DATE KNOWN OF DEATH EST. MATED		MONTH	DAY	YEAR	12. HOUR		
George							Easter			12/1/80		11 P.M.					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		9. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	12. HOUR
M		B		4 28 98		81 yrs.						12/24/80		10 P.M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH									
99		✓						Talbot County MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Easton		Route 4, Box 639										Farmer		Farm			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS									
Md.		Tal.		Easton		YES <input type="checkbox"/>		Route 4, Box 639									
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST							
Unkn.																	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
Unkn.		231-01-1047															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):) PART I DEATH WAS CAUSED BY: 303- IMMEDIATE CAUSE (a) <i>Hypothetical</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
(b) <i>Alcoholism</i> DUE TO, OR AS A CONSEQUENCE OF																	
(c) <i></i>																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?					
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) 19													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/>		Inspection <input type="checkbox"/>		Inquiry <input checked="" type="checkbox"/>		and in my opinion									
ACTUAL SIGNATURE <i>R. G. G. W. M. T.</i>		TITLE (SPECIFY) M.D.		Reputed		MEDICAL EXAMINER											
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE							
Removal		1-31-80															
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
✓ Anatomy Board		Balto., Md.		FEB 07 1980		Larry McCreary											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, post it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80002513							
REG. NO.																			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR							
Dorothy Ethel Fox						January 2, 1980						M							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS							
Female		Caucasian		Nov. 4, 1909			70			MONTHS		DAYS							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH												
Washington D.C.		U.S.A.					Talbot												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Easton		505 Bridge Street			Secretary-Clerk														
13a. STATE Maryland												13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 505 Bridge Street	
14. FATHER'S NAME FIRST MIDDLE LAST												15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
John W. Thompson		Jeannette M. Sloan																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. ADDRESS												
No		578-32-3582		Lois G. Webb			205 Prospect Ave. Easton, Maryland												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>coronary artery disease</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-5 years							
4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) <i>atherosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>severe congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Hypothyroidism — Psoriasis — obesity —</i>																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE								
22a. I certify that (I) (this hospital) attended the deceased from <i>1973</i> , 19 <i>77</i> , to <i>1980</i> , 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>1979</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (Did) (Did not) view the body after death.																			
22b. SIGNATURE <i>Albert T. Dawkins, Jr.</i>		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 1/3/80											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			14 N. Aurora St., Easton, Maryland														
Albert T. Dawkins, Jr., M.D.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-5-80		23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln			23d. LOCATION CITY OR TOWN Bladensburg			COUNTY Prince Georges	STATE Md.								
24. FUNERAL DIRECTOR NAME Newnam Funeral Home		ADDRESS 200 S. Harrison St. Easton, Maryland		25a. DATE REC'D. BY REGISTRAR JAN 7 1980			25b. REGISTRAR'S SIGNATURE <i>John Newnam</i>												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 02514	REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
Thomas Connolly Gannon						JANUARY 21 1980						30 9 P.M.					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS					
Male		White		December 7, 1898			81			MONTHS	YEARS	MONTHS	HOURS	MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.							
Maryland		USA					Talbot										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Easton		THE MEMORIAL Hospital		Contractor			Building										
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS							
Maryland		QueenAnne's		Centreville			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			229 North Commerce Street							
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST							
Nathaniel		Harrison		Gannon	Mary			Katherine		Connolly							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
No		220-01-8670		Son			i-15-80										
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY																	
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>																	
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost																	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease</u>																	
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
none																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
19b. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE					
22a. I certify that (this hospital) attended the deceased from 1-15, 1980, to 1-21, 1980, that (we) lost saw the deceased alive on 1-21, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) did (did not) view the body after death.																	
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN			MEDICAL DIRECTOR		STAFF PHYSICIAN		22c. DATE SIGNED					
Robert W. Trever, M.D.												1-22-80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			RD 3			Easton		Md. 21601							
Robert W. Trever, M.D.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE					
Burial		Jan. 24, 1980		Woodlawn Memorial Park			Easton, Talbot, Md.										
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR			25b. REC'D. BY REGISTRAR'S SIGNATURE										
Barton Bros.		James H. Barton, Jr. Centreville, Md.		JAN 28 1980			Henry McCreedy										

Joseph H. Teeter, M.D.

James H. Maxfield, Creative

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 3002515	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH ESTIMATED			2b. HOUR ? M	
Lil Fred W. Gordon									1/9 1980				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		9. DATE PRONOUNCED DEAD	
female		white		7-29-1916		63 yrs.						January 13 1980 1P.M.	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			11. CITIZEN OF WHAT COUNTRY?			12. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			13. BALTIMORE CITY OR COUNTY OF DEATH				
Tenn.			U.S.						Talbot				
14. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN NURSING FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Easton			The Memorial Hospital			housewife							
13a. STATE Maryland			13b. COUNTY Talbot		13c. CITY OR TOWN Trappe		13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS R.D. #1 Howell's Pt. Road				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
Douglas Massey Wright, Sr.			Margaret Fall										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. 411-24-7685			17. INFORMANT William H. Price, 11			ADDRESS Easton, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4149 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. DUE TO, OR AS A CONSEQUENCE OF Hypertension												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(b) DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Obstruction													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?							
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE R. Lane Wroth, M.D. TITLE (SPECIFY) M.D. MEDICAL EXAMINER												DATE SIGNED 1-14-80	
EXAMINER'S NAME (TYPE OR PRINT)			R. Lane Wroth, M.D.			ADDRESS St. Michaels, Md. 21663							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 1-14-1980			23c. NAME OF CEMETERY OR CREMATORIAL Delmarva Crematory			23d. LOCATION CITY OR TOWN Lewes, Sussex, Delaware COUNTY STATE				
24. FUNERAL DIRECTOR Newham Funeral Home			ADDRESS Easton, Md.						25a. DATE REC'D. BY REGISTRAR JAN 17 1980			25b. REGISTRAR'S SIGNATURE Lester Newham	
BP													
DHMH - 17 (VR A15 ME (5)) 30M 7/73													

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, pending should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80002516										
REG. NO.																						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR										
LILLIAN CATHELEEN HAMMOND									JANUARY 11, 1980			4-15 AM										
3. SEX FEMALE			4. RACE BLACK			5. DATE OF BIRTH MONTH DAY YEAR JULY 12, 1907			6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN								
7a. BIRTHPLACE (STATE OR FOREIGN) CAROLINE COUNTY			7b. CITIZEN OF WHAT COUNTRY? UNITED STATES			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT			10. CITY OR TOWN OF DEATH EASTON, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL, EASTON, MD.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (HOUSEWIFE)			12b. KIND OF BUSINESS OR INDUSTRY NONE		
13a. STATE MARYLAND			13b. COUNTY CAROLINE			13c. CITY OR TOWN FEDERALSPURG			13d. INSIDE/OUTSIDE LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS RT# 2 BOX# 16 MARYLAND			14. FATHER'S NAME WILLIAM NM BAYNARD			15. MOTHER'S MAIDEN NAME REBECCA (NM) THOMAS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. NO			16c. RECORDS OF MEMORIAL HOSPITAL EASTON, MD.			17. INFORMANT RECORDS OF MEMORIAL HOSPITAL EASTON, MD.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 MONTHS							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d. LOCATION STREET CITY OR TOWN COUNTY STATE													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. DATE SIGNED JAN 12, 1980																
22a. I certify that (I) (this hospital) attended the deceased from DEC 12, 1979, to JAN 11, 1980, that (I) (we) last saw the deceased alive on JAN 11, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE STEPHEN R. CARNER, M.D.			22c. DEGREE			22d. DATE SIGNED JAN 12, 1980													
22e. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN R. CARNER			22f. ADDRESS DUTCHMAN'S LANE EASTON, MARYLAND																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE JAN 14, 1980			23c. NAME OF CEMETERY OR CREMATORIAL FEDERAL HILL CEMT			23d. LOCATION CITY OR TOWN COUNTY STATE FEDERALSPURG, CAROLINE MARYLAND													
24. FUNERAL DIRECTOR NAME CHARLES W. HILL, DENTON, MD.			25a. DATE REC'D. BY REGISTRAR JAN 16 1980			25b. REGISTRAR'S SIGNATURE LAWRENCE																

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILE.

TO FUNERAL DIRECTOR: PAGE 2 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Francis Clifford Hane				FIRST Francis	MIDDLE Clifford	LAST HANE	2a. DATE KNOWN OF ESTI- DEATH MATED 15 1980	MONTH 15	DAY 1980	YEAR 35A	2b. HOUR 35A	
3. SEX M	4 RACE W	5. DATE OF BIRTH MONTH 4	DAY 11	AGE (IN YEARS LAST BIRTHDAY) 68 71	IF UNDER 1 YR. YRS.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD 1-5 1980	MONTH 1-5	DAY 1980	YEAR 35B	2d. HOUR 35B	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot					
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT A HOSPITAL, GIVE STREET ADDRESS) Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney		12b. KIND OF BUSINESS OR INDUSTRY Legal					
13a. STATE Md		13b. COUNTY Quarantine		13c. CITY OR TOWN Queenstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Main Street, P.O. Box 201					
14. FATHER'S NAME FIRST James		MIDDLE Edward	LAST Hane, Sr.	15. MOTHER'S MAIDEN NAME FIRST Catherine		MIDDLE -----	LAST Hoehn					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II		17. INFORMANT Wife Mrs. Katheryne H. Hane		ADDRESS Queenstown, Md. 21617						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 410- Coronary Occlusion		IMMEDIATE CAUSE (a) Arteriosclerotic heart disease		DUE TO, OR AS A CONSEQUENCE OF 67 years		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		(b) Arteriosclerotic heart disease		DUE TO, OR AS A CONSEQUENCE OF								
(c) -----												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Louis S. Welty</i>		TITLE (SPECIFY) M.D. <i>for some</i>		MEDICAL EXAMINER		DATE SIGNED 1-5-80						
EXAMINER'S NAME (TYPE OR PRINT) Louis S. Welty		ADDRESS Easton Md										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 8, 1980		23c. NAME OF CEMETERY OR CREMATORIAL St. Peter's Cemetery		23d. LOCATION CITY OR TOWN Queenstown, Q.A. Co., Md.		COUNTY		STATE		
24. FUNERAL DIRECTOR NAME Barton Bros.		ADDRESS James H. Barton, Jr., Centreville, Md. 21617		25a. DATE REC'D. BY REGISTRAR JAN 14 1980		25b. REGISTRAR'S SIGNATURE <i>Louis Welty</i>						

100-131891

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial and transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. With the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8002518		
REG. NO.														
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			James W.			Hoffman			1 - 2 - 80			12 AM		
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Male			White			February 13, 1913			66 YRS.			MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS		
Church Creek, Md.			U.S.A.						Talbot			MONTHS HOURS MIN		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			MD.		
EASTON			Memorial			Store Proprietor			Gas & Grocery					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		
Maryland			Caroline			Denton						195D Legion Road		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS		
Joseph Emory Hoffman			Sarah Amanda Collins			220-09-1800			Mrs. Cecelia Hoffman, 195D Legion Rd., Md.			Denton, 21629		
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bram Stein Sloffe</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4292 5 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCD</u> 7 yrs DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Hypertension</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>1929</u> , to <u>1980</u> , that (I) (we) last saw the deceased alive on <u>11/11/77</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If we did not see the body after death, state cause of death.														
22b. SIGNATURE			22c. DEGREE			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED					
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS									1/28/80		
Donald T. Lewers, M.D.			Easton, Md. 21601											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY STATE		
Burial			Jan. 4, 1980			Concord Cemetery			Denton, Caroline, Maryland					
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Flemington-Hawkins F.H. - FEDERALSBURG.			Box 43			JAN 1980								

24

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8002519
REG. NO.

1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR						2b. HOUR		
1 DECEASED NAME (TYPE OR PRINT)			LAST			JANUARY 26 1980			2 27		
Lawrence Jenkins			Jenkins								
3 SEX Male		4 RACE Negro		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS	
				March 28, 1904		75		YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Florence, S.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		7c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.					
10 CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial		12e. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Chef						12b. KIND OF BUSINESS OR INDUSTRY Hospital	
13a. STATE Maryland		13b. COUNTY Caroline		13c. CITY OR TOWN Federalsburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 2, Box 384			
14. FATHER'S NAME Charles Jenkins, Sr.						15. MOTHER'S MAIDEN NAME Martha Woodbury					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 166-09-9614A		17. INFORMANT Mrs. Edith A. Jenkins, Rt. 2, Box 384, Md.		ADDRESS Federalsburg, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma (R) maxillary</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1602 2 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any (b) <u>c probable CNS</u> SINCE (c) <u>metastasis</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Sep</u> , 19 <u>78</u> , to <u>Jan 26</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>Jan 25</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>DR H. W. Friedel</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/26/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DR H. W. Friedel</u>		22e. ADDRESS <u>29 Cramery Lane Easton Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 30, 1980		23c. NAME OF CEMETERY OR CREMATORIUM Federal Hill Cemetery		23d. LOCATION CITY OR TOWN Federalsburg		CITY OR TOWN Caroline		STATE Md.	
24. FUNERAL DIRECTOR <u>FRAMPTON- HAWKINS BOX 113 FEDERALSBURG</u>		ADDRESS 216 N. Main St.		25a. DATE REC'D. BY REGISTRAR JAN 30 1980		25b. REGISTRAR'S SIGNATURE <u>Patricia McCleary</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TD FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

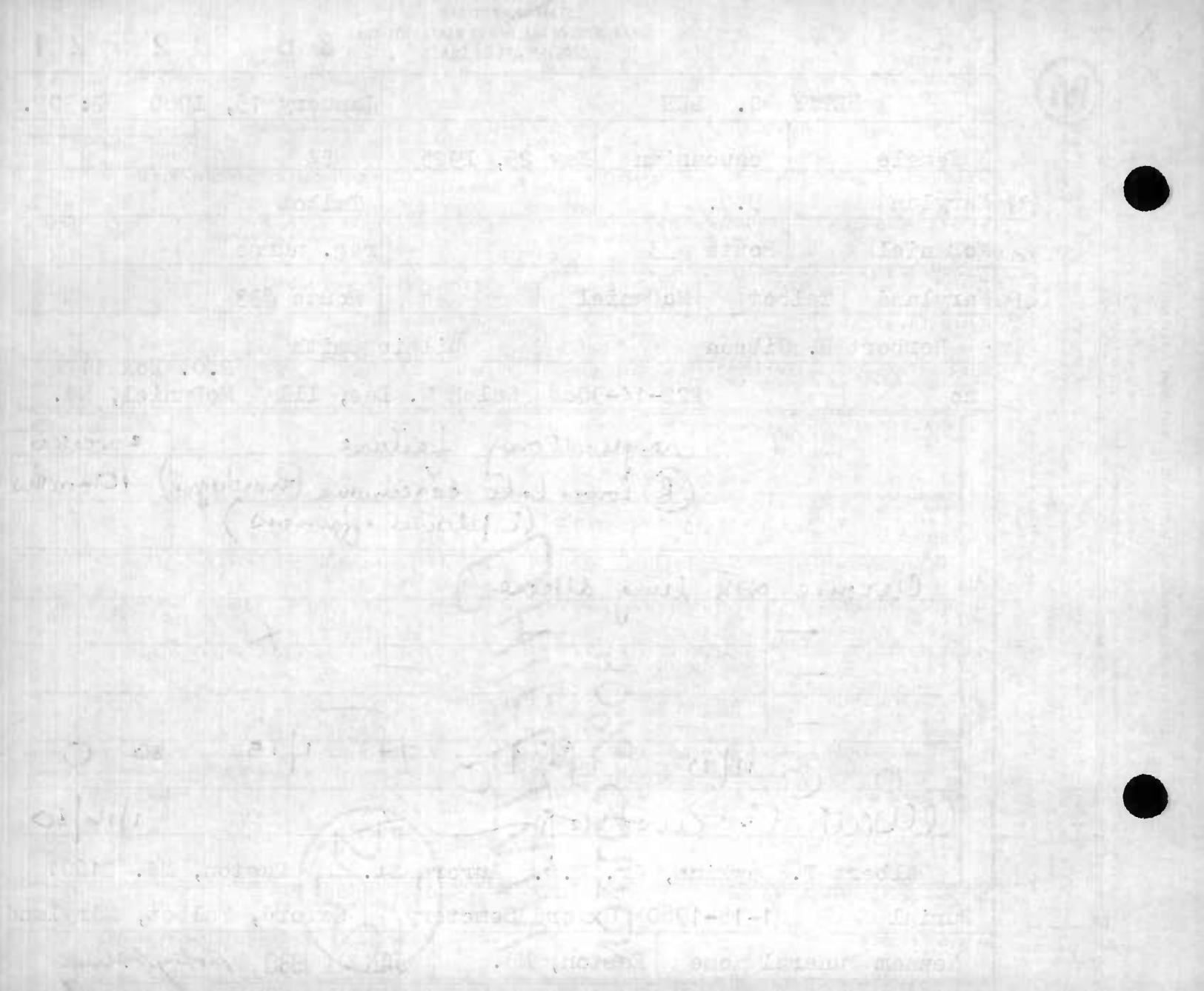
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8002520 REG. NO.		
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR		
Oscar Kinnaman									1-10-80			7:25 p.m.		
3. SEX Male			4. RACE Cau.			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			Sept. 8, 1894			85					
8. CITY OR TOWN OF DEATH Easton			9. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital						10a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer			10b. KIND OF BUSINESS OR INDUSTRY Farming		
11a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md.			11b. COUNTY Caroline			11c. CITY OR TOWN Denton			12a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			12b. STREET ADDRESS Rt 313		
14. FATHER'S NAME Charles Kinnaman									15. MOTHER'S MAIDEN NAME Annie Dill					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO WW 1			17. INFORMANT Elsie C. Kinnaman			18. ADDRESS Denton, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)														
DUE TO, OR AS A CONSEQUENCE OF (b)														
DUE TO, OR AS A CONSEQUENCE OF (c) <i>ASCVD</i>														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 19 77 to 1-10 19 80, that (I) (we) last saw the deceased alive on 1-10 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not (did not) view the body after death)														
22b. SIGNATURE <i>Terry Dietrich, M.D.</i>			22c. DEGREE M.D.			22d. DATE SIGNED JAN 16 1980								
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Terry Dietrich, M.D.			22f. ADDRESS 140 S. Wash. St. Easton, Md. 21601											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-13-80			23c. NAME OF CEMETERY OR CREMATORIAL Greensboro			23d. LOCATION CITY OR TOWN Greensboro COUNTY Caroline STATE Md.					
24. FUNERAL DIRECTOR NAME John C. Boulaire			ADDRESS Brandenburg, Md.			25a. DATE REC'D. BY REGISTRAR JAN 16 1980			25b. REGISTRAR'S SIGNATURE <i>P. Day, Secretary</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of issue with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 0 2 5 2 1	REG. NO.					
1 - FOR STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
BETTY G. LEE									January 15, 1980			2:30 P.M.				
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
female			caucasian			May 25, 1925			54 yrs							
7a. BIRTHPLACE COUNTRY Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Talbot			MD.				
10. CITY OR TOWN OF DEATH McDaniel			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Route #33			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) reg. nurse			12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Maryland			13b. COUNTY Talbot			13c. CITY OR TOWN McDaniel			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Route #33				
14. FATHER'S NAME FIRST MIDDLE LAST Herbert R. Gibson						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Wilsie Smith										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 222-14-9088			17. INFORMANT Ralph W. Lee, 111 McDaniel, Md.			18. ADDRESS P.O. Box 112							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629			respiratory failure									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.			DUE TO, OR AS A CONSEQUENCE OF (b) <input checked="" type="checkbox"/> lower lobe carcinoma (tracheogen) 10 months													
			DUE TO, OR AS A CONSEQUENCE OF (c) <input type="checkbox"/> (i) pleural effusions													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED —			ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET — CITY OR TOWN — COUNTY — STATE —										
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 19 29 80 above (I) (we) (did) (did not) view the body after death.			22b. DATE SIGNED 1/16/80			19 74 to 19 80, the (I) (we) lost and that in (my) (our) opinion death occurred on the date and hour and from the causes stated										
22c. SIGNATURE Albert T. Dawkins			22d. ATTENDING PHYSICIAN Albert T. Dawkins, Jr. M.D.			22e. MEDICAL DIRECTOR STAFF PHYSICIAN <input type="checkbox"/>			22f. DATE SIGNED 1/16/80							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS Aurora St. Easton, Md. 21601													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-18-1980			23c. NAME OF CEMETERY OR CREMATORIAL Oxford Cemetery			23d. LOCATION CITY OR TOWN Oxford, Talbot, Maryland			STATE COUNTY				
24. FUNERAL DIRECTOR NAME Newnam Funeral Home			ADDRESS Easton, Md.			25a. DATE REC'D. BY REGISTRAR JAN 21 1980			25b. REGISTRAR'S SIGNATURE Mary McCreedy							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8002522
REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
<i>Dorothy B. Madary</i>						<i>January</i>	<i>20, 1980</i>			<i>12:05 AM</i>	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)			7a HOUR		
Female		White		MONTH 5/30/1906 DAY YEAR		73			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Maryland		U.S.A.				<i>Talbot</i>					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY				
<i>EASTON</i>		<i>Memorial Hospital</i>		Secretary			Insurance				
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS			
Md.		Talbot		Easton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		P.O. Box 338 21601			
14 FATHER'S NAME		FIRST	MIDDLE	LAST	15 MOTHER'S MAIDEN NAME		16 ADDRESS				
Richard				Buckmaster	Mary B.		Nicholson				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		18 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No		212.01.6108		Charles R. Madary---Same as 13e							
18 CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carcinoma of the colon</i>											
1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), (c)											
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a I certify that (I) (this hospital) attended the deceased from 3, 1974, to 1/20, 1980, that (I) (we) lost sow, the deceased alive on 1/18, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <i>William J. Banfield</i> DEGREE <i>MD</i> ATTENDING MEDICAL STAFF PHYSICIAN DIRECTOR PHYSICIAN									22c DATE SIGNED <i>1/20/1980</i>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>WILLIAM J. BANFIELD M.D.</i>									22e ADDRESS		
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE 1/21/1980		23c NAME OF CEMETERY OR CREMATORIAL Green Mount			23d LOCATION CITY OR TOWN Baltimore		COUNTY		STATE
Cremation											Md.
24 FUNERAL DIRECTOR NAME <i>Walter Brooks Bradley Inc.</i>		ADDRESS <i>Dundalk, Md.</i>		25a DATE REC'D. BY REGISTRAR JAN 23 1980			25b REGISTRAR'S SIGNATURE <i>John Brooks</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

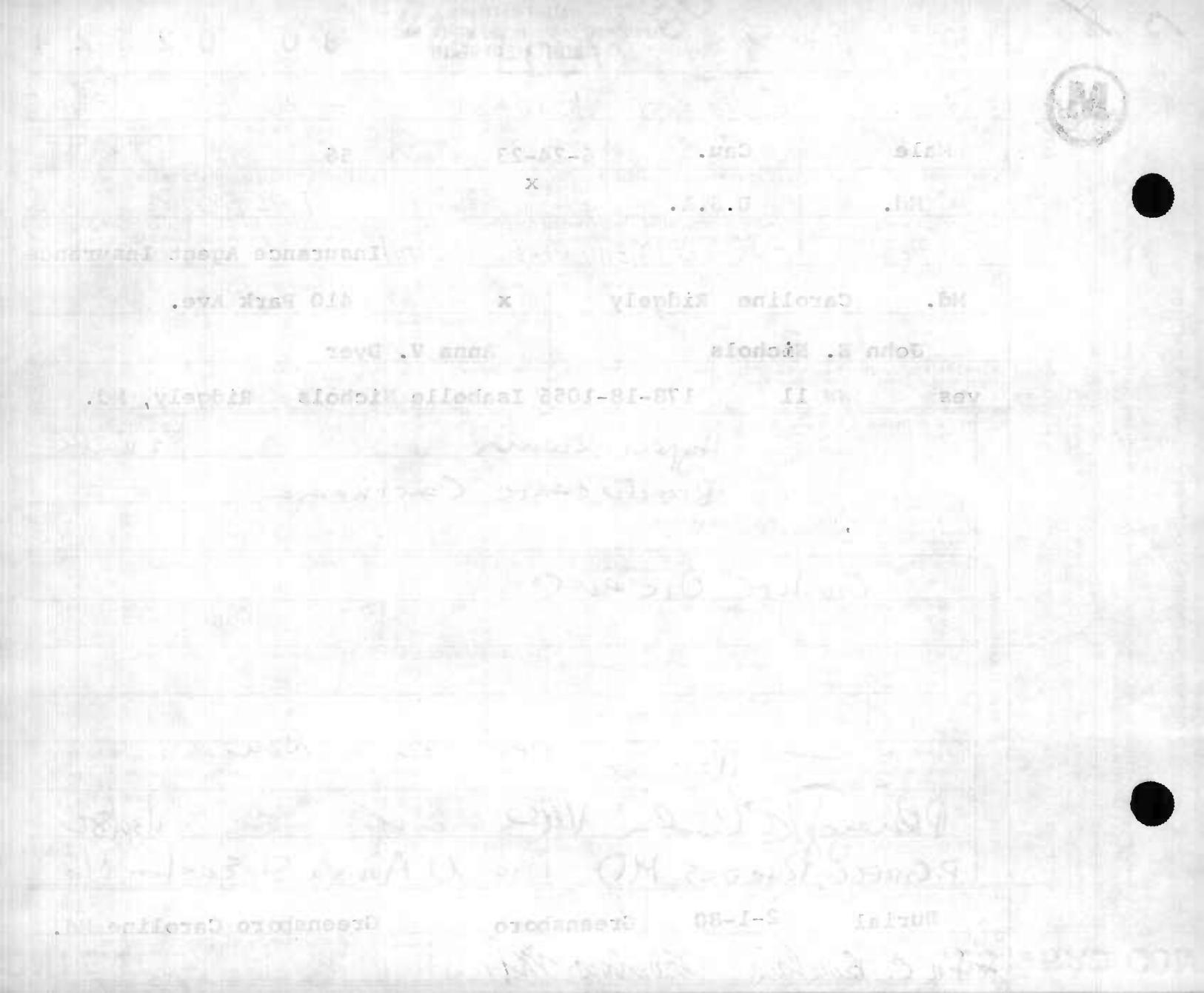
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8002523	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	05		
NELSON			Edward	McGrath		1 - 30	80			11 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN			
Male		White		July 13, 1899		80							
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		7c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		U.S.				Talbot							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Eastern			The MEMORIAL Hospital			Construction			worker				
13a. STATE Md.			13b. COUNTY Dor.		13c. CITY OR TOWN Cambridge	14. FATHER'S NAME Charles Edward McGrath		15. MOTHER'S MAIDEN NAME Cora Mae Hurley		16. ADDRESS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
YES			W.W.1		220-01-9962		Mary S. McGrath, Cambridge, Md.			3 MONTHS			
1539			CITRICINERATOSIS										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any			(b)		DUE TO, OR AS A CONSEQUENCE OF CITRICINERATOSIS					17 MONTHS			
			(c)		DUE TO, OR AS A CONSEQUENCE OF CITRICINERATOSIS								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION AUGUST 1978			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA colon			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (we) attended the deceased from 1980 to 1980, that (I) (we) last saw the deceased alive on 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE C. M. BROWN			22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 1/30/80					
22f. PHYSICIAN'S NAME (TYPE OR PRINT) C. M. BROWN			22g. ADDRESS Boston Rd. 21601										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 3, 1980			23c. NAME OF CEMETERY OR CREMATORIAL Cem. East New Mkt., Dor., Md.			23d. LOCATION CITY OR TOWN		COUNTY	STATE	
24. FUNERAL DIRECTOR NAME Thomas Funeral Home Cambridge, Md.			25a. DATE REC'D. BY REGISTRAR FEB 7 1980			25b. REGISTRAR'S SIGNATURE Patsy McElroy							
ADDRESS													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 02524					
REG. NO.																	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2. DATE OF DEATH			MONTH	DAY	YEAR	20. HOUR					
Leon			Edward	Nichols		1-30-80						8:20 A					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
Male		Cau.		MONTH	DAY	YEAR	56			MONTHS	YEARS	HOURS	MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH										
Md.		U.S.A.					TALBOT			MD.							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
78 Easton			188 EASTON MEMORIAL Hospital									Insurance Agent			Insurance		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS							
Md.			Caroline		Ridgely		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			410 Park Ave.							
14. FATHER'S NAME			MIDDLE		LAST	15. MOTHER'S MAIDEN NAME			ADDRESS								
John E. Nichols						Anna V. Dyer											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO		17. INFORMANT			ADDRESS									
yes			WW 11		178-18-1056 Isabelle Nichols			Ridgely, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
IMMEDIATE CAUSE (a) 1629			2 month														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF (b) Hypercalcemia														
			DUE TO, OR AS A CONSEQUENCE OF (c) Bronchogenic carcinoma														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
Gastro Ulcer																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE						
22a. I certify that (I) (this hospital) attended the deceased from Dec. 19 80 to Now, that (I) (we) last saw the deceased alive on 1/20 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not then view the body after death.																	
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED								
P. Gregg Rhodes MD									1/30/82								
22d. ADDRESS			21601 14 W Aurora St, Easton, Md.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY	STATE						
Burial			2-1-80		Greensboro			Greensboro		Caroline	Md.						
24. FUNERAL DIRECTOR			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
John C. Boukris			Greensboro, Md.			FEB 0 1980			merry munday								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon paper. Please 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon paper. Please 3 and 2 should be filled within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8002525											
												REG. NO.											
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			20. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
			<i>Honor</i>									<i>Peele</i>			1-11-80			12	12	12	6 AM		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS								
Female			White			MONTH DAY YEAR July 5, 1930			49 YRS			MONTHS DAYS			HOURS MIN								
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Providence, R.I.			U.S.A.			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			<i>Talbot</i>			Easton			<i>The Memorial Hospital</i>			Nurses Aid			Easton Hospital		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS											
Maryland			Caroline			Federalsburg			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Rt. 2, Box 343											
14. FATHER'S NAME			FIRST			LAST			15. MOTHER'S MAIDEN NAME			FIRST			LAST								
Charles Davis									Elizabeth Nettleton														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS														
No			261-40-4584			Brooks B. Peele, Rt. 2, Box 343, Federalsburg,			Maryland 21632														
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
IMMEDIATE CAUSE (a) <i>4254</i>												<i>Patronay Edema</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b).</i>												<i>Cardiomyopathy</i>											
DUE TO, OR AS A CONSEQUENCE OF (c)												10 yrs											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that (1) (this hospital) attended the deceased from 1-14, 1977, to 1-11, 1980, that (1) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.												22b. DATE SIGNED <i>1/14/80</i>											
22c. SIGNATURE <i>Thomas Fauntleroy, M.D.</i>			22d. DEGREE <i>M.D.</i>			22e. ATTENDING PHYSICIAN <input type="checkbox"/>			22f. MEDICAL DIRECTOR <input type="checkbox"/>			22g. STAFF PHYSICIAN <input type="checkbox"/>											
22h. PHYSICIAN'S NAME (TYPE OR PRINT)			22i. ADDRESS			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE		
Burial			Jan. 14, 1980			Hillcrest Cemetery			Federalsburg, Caroline, Md.														
24. FUNERAL DIRECTOR NAME <i>Desti Lee</i>			ADDRESS 216 N. Main St. Federalsburg, Md.			25a. DATE REC'D. BY REGISTRAR JAN 21 1980			25b. REGISTRAR'S SIGNATURE <i>Henry McCreedy</i>														

BP

DHMH-16 25M
(VRA 15, 4) 1/79

133 2. Map. 2f. Section. Mg. 51201

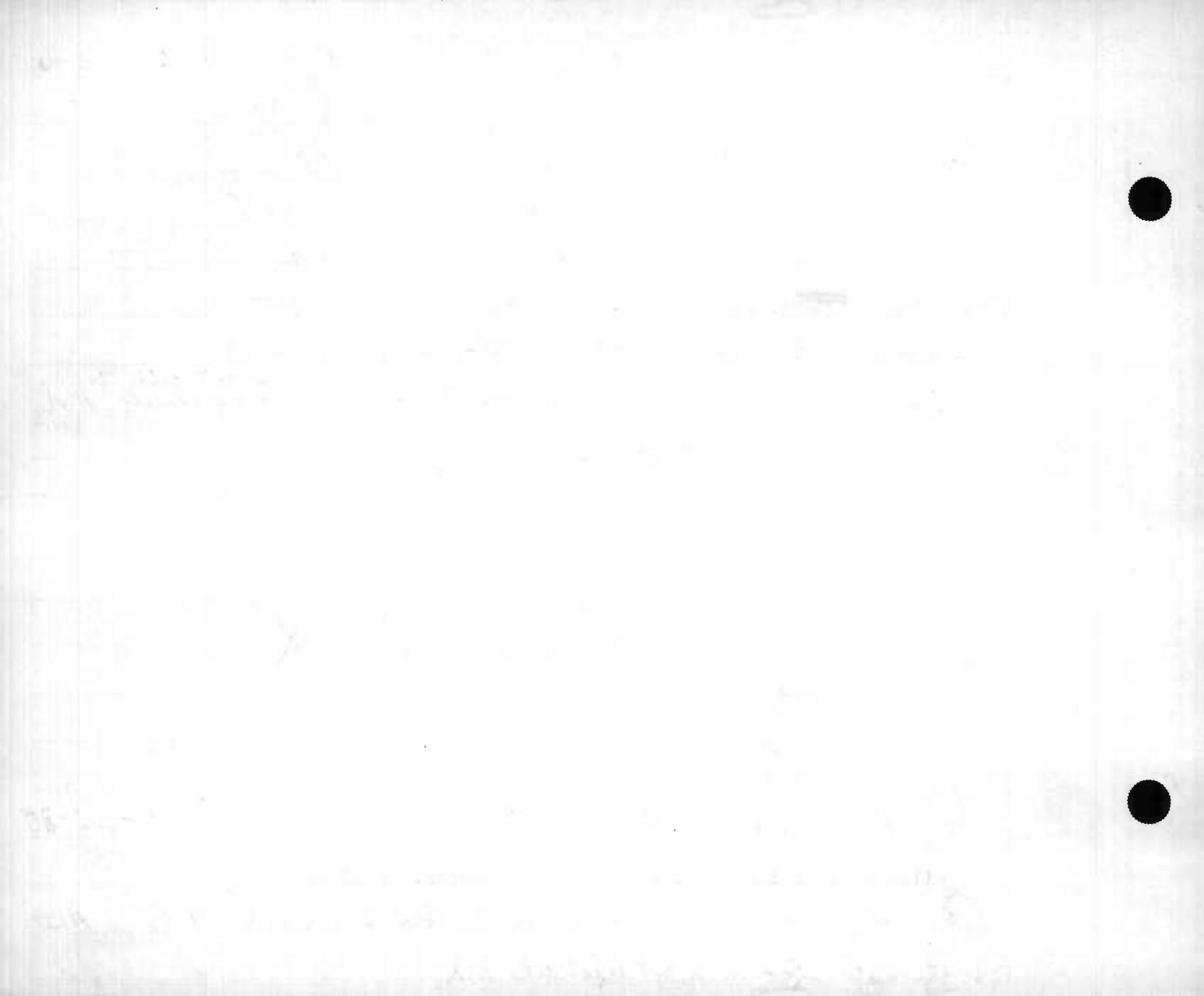
U.S. House Estoppel Report

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 80 02526			
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			LAST			20. DATE OF DEATH MONTH DAY YEAR			21. HOUR			
Margaret			PERRY			1/21 80			18		M				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE		N		MONTH DAY YEAR			88			MONTHS DAYS		HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
MD.		USA		TALBOT			MD.								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
EASTON		The Memorial Hosp.		unk			unk								
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS						
MARYLAND		CAPTAINLINE		MARYDEL			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		unk						
14. FATHER'S NAME		15. MOTHER'S MÄDEN NAME													
JOHN F. MADDUX		MANNIE DAVIS													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
No		—		—		LEON FOUNTAIN		14 North St. St. Michael, Md.							
18. CAUSE OF DEATH: (Enter only one cause per line for (a), (b), and (c).)															
PART 1. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) ASCVD															
4292															
DUE TO, OR AS A CONSEQUENCE OF															
(b)															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		HOUR A.M. MONTH DAY YEAR			P.M. 19		21e. LOCATION		STREET			CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 11 19 80 to 1 19 80, that (I) (we) last saw the deceased alive on 11 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE															
William J. Banfield, M.D. MD															
DEGREE															
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>															
22c. DATE SIGNED															
1-22-80															
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION		23e. COUNTY		23f. STATE				
Cremation Jan 23 1980		7t. Lincoln Cemetery		Brentwood			F.G.		MD.						
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REG'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
James E. Leonard		Dr. Michaels, Md.		JAN 25 1980											



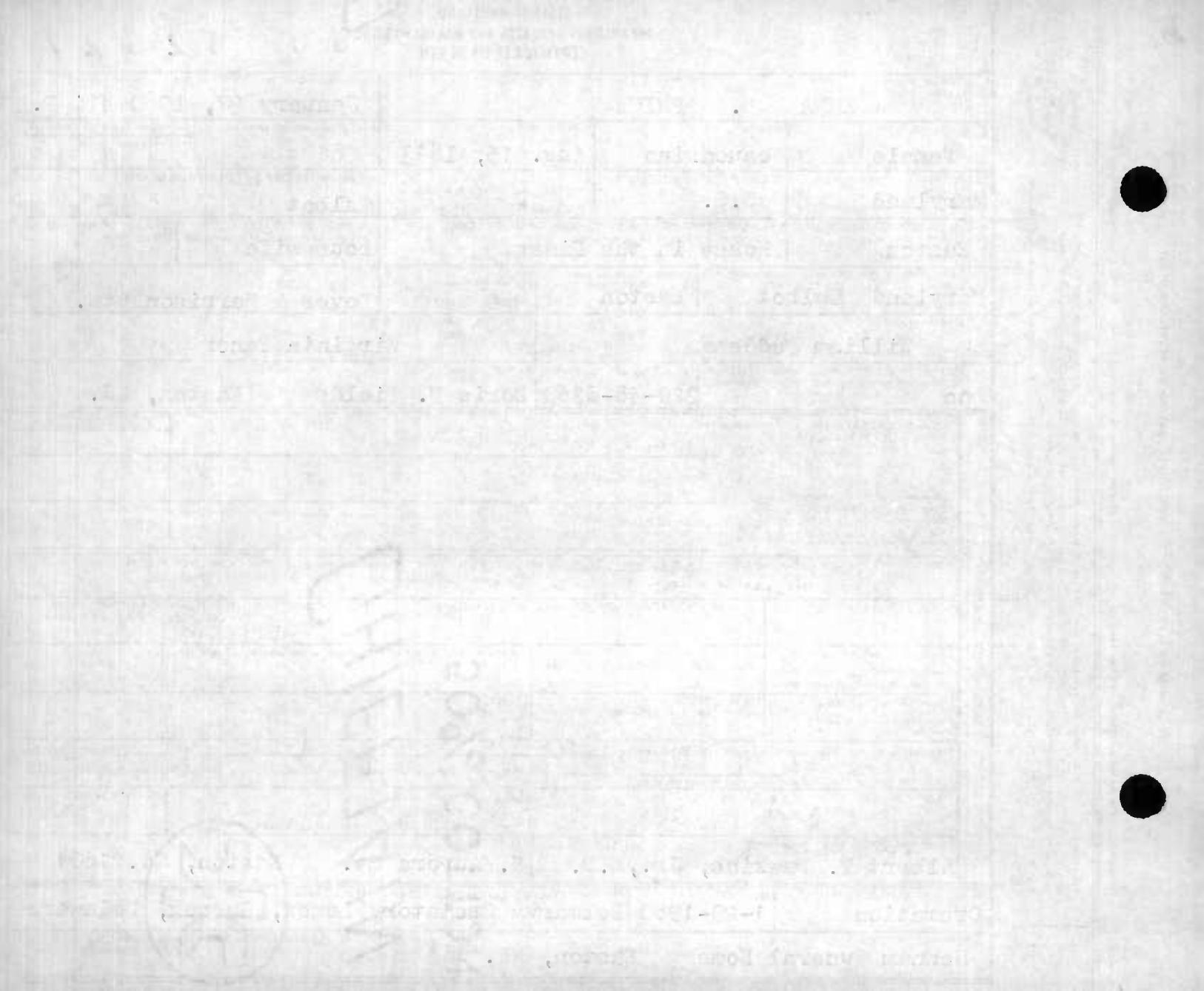
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8002527		
REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
EMMA D. PRICE						January 27, 1980			11 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
female		caucasian		Aug. 15, 1893			86			YRS.		
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Maryland		U.S.					Talbot					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Easton		House in the Pines		housewife								
13a. STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Easton			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Dover & Harrison Sts.			
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 220-46-6260		
				Virginia Tanor						17. INFORMANT Doris P. Fields		
										ADDRESS Easton, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours		
4289 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)												
DUE TO, OR AS A CONSEQUENCE OF (b)												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
Hyper tension.		L. Hypertension										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 1/21/80, 19_____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					19_____, to 1/21/80, 19_____, that (I) (we) lost							
22b. SIGNATURE C. M. Brown					DEGREE MD			22c. DATE SIGNED 1/28/80				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert T. Dawkins, Jr., M.D.					ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 1-29-1980			23c. NAME OF CEMETERY OR CREMATORIAL Delmarva Crematory			23d. LOCATION CITY OR TOWN Lewes, Sussex, Delaware				
24. FUNERAL DIRECTOR NAME Newham Funeral Home		ADDRESS Easton, Md.			25a. DATE REC'D. BY REGISTRAR FEB 1 1980			25b. REGISTRAR'S SIGNATURE L. Murphy				



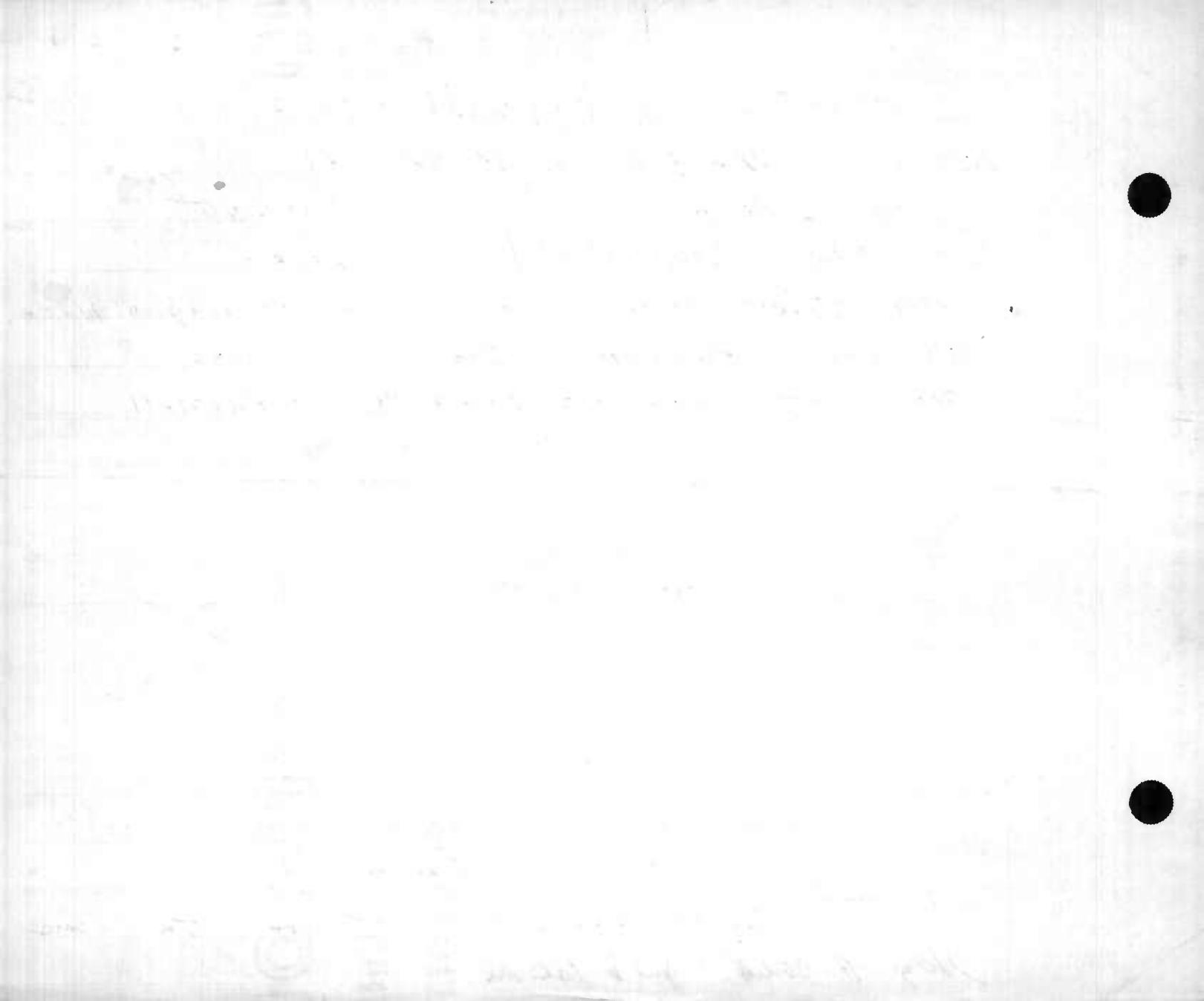
TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8002528											
										REG. NO.											
1 - STATE REGISTRAR																					
1a. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR						
Male			Negro			Martie E Purnell			1-21-80						955 AM						
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			7 IF UNDER 1 YEAR			8 IF UNDER 14 HRS						
Male			Negro			2 18 98			81			YRS.			MONTHS DAYS HOURS MIN						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.									
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY												
Easton			Memorial			13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. STREET ADDRESS												
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS									
Md			Talbot			Easton			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			100 thought good home									
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT									
William			Purnell			Ida			218-20-7435			Elizabeth									
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			18b. PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			18c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
No			Acute myocarditis			2051															
18d. DUE TO, OR AS A CONSEQUENCE OF (b)			18e. DUE TO, OR AS A CONSEQUENCE OF (c)			18f. DUE TO, OR AS A CONSEQUENCE OF (d)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										Heart failure											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?												
19b. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20a. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)															
21a. WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21c. LOCATION STREET			CITY OR TOWN			COUNTY			STATE						
22a. I certify that (I) (this hospital) attended the deceased from 1/21/80 to 1/22/80, 19, 19, that (I) (we) last saw the deceased alive on 1/21/80, 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE C. W. Bain										DEGREE											
22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										22e. DATE SIGNED 1/22/80											
22e. ADDRESS Easton, Md																					
23a. BURIAL, CREMATION, REMOVAL (SELECT)			23b. DATE 1/26/80			23c. NAME OF CEMETERY OR CEMETARY Paradise			23d. LOCATION CITY OR TOWN Trappe			COUNTY Md			STATE						
24. FUNERAL DIRECTOR NAME George H. Ashell										25a. DATE REC'D. BY REGISTRAR JAN 28 1980			25b. REGISTRAR'S SIGNATURE Loyalty Belknap								
ADDRESS Just & Eaton Rd																					
DHMH-16 20M (VRA 15, 4) 7/78																					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, please remove carbon papers. Pages 1 and 2 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8002529
REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)	FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
KIP H. REQUARDT	KIP		H.		REQUARDT		January 12, 1980					4: P M
3. SEX female	4. RACE caucasian		5. DATE OF BIRTH MONTH Apr. 20, 1921		YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.	7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Talbot		MONTHS		DAYS	
10. CITY OR TOWN OF DEATH Oxford	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bachelors Point		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY MD.							
13a. STATE Maryland	13b. COUNTY Talbot		13c. CITY OR TOWN Oxford		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Bachelors Point		13f. STREET ADDRESS			
14. FATHER'S NAME John G. S. Humphreys	15. MOTHER'S MAIDEN NAME Doris Taylor											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes	16b. SOCIAL SECURITY NO. W.W. 11 465-34-9749		17. INFORMANT Wendy C. R. Jeffra		ADDRESS P.O. Box 595 Easton, Md.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1729 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
DUE TO, OR AS A CONSEQUENCE OF (b)												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>Sep 19 1980</u> to <u>12 Jan 1980</u> , that (I) (we) last saw the deceased alive on <u>11 Jan 1980</u> , one shot in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Stephen P. Carney, M.D.</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-13-80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen P. Carney, M.D.		22e. ADDRESS Dutchman's Lane		22f. ADDRESS Easton, Md. 21601								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 1-13-1980		23c. NAME OF CEMETERY OR CREMATORIAL Delmarva		23d. LOCATION CITY OR TOWN Lewes, Sussex, Del.		COUNTY		STATE		
24. FUNERAL DIRECTOR NAME Newnam Funeral Home		ADDRESS Easton, Md.		25a. DATE REC'D. BY REGISTRAR JAN 16 1980		25b. REGISTRAR'S SIGNATURE <i>Stephen P. Carney</i>						

08011421

FOR STATE
HEALTH DEPT.

RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give copy 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with copy 5. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 2 and 3 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 24 hours of death.

DHMH-17 1/71 10M (VR A15M (5))

Items 18, 21a-22a G541 3/27/80 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02530

1. DECEASED-NAME (Type or Print)	First John	Middle Melvin	Last Schwaninger	20. DATE KNOWN <input type="checkbox"/> Month 1 Year 1980 OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 1/27 1980 2b. HOUR 2:30 P.M.		
3. SEX male	4. RACE white	5. DATE OF BIRTH 4-25-1921	6. AGE (In years last birthday) 58 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD Month / Day - 27 Year 1980 2d. HOUR 3:45 P.M.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Talbot			
10. CITY OR TOWN OF DEATH Easton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Foreman		12b. KIND OF BUSINESS OR INDUSTRY Highway Dept
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland	13b. COUNTY Talbot	13c. CITY OR TOWN Trappe	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER R.D. #2, Box 22		
14. FATHER'S NAME John Henry Schwaninger	First Middle	Lost	15. MOTHER'S MAIDEN NAME Grace Brinsfield			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) no	16b. SOCIAL SECURITY NO. 118-16-6228	17. INFORMANT Dorothy J. Schwaninger	ADDRESS see item 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	Coronary occlusion			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(b) DUE TO, OR AS A CONSEQUENCE OF lost.	(i)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH 240 P.M. 1/27 1980		21b. TIME OF INJURY Month, Day, Year HOUR A.M. / 27 1980	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 item 18.) Wove off road into ditch.			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) Talbot	21f. LOCATION Street or R.F.D. No. R 331 Talbot, Md.	City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE R. Lane Wroth, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.			22b. DATE SIGNED 1-29-80	
EXAMINER'S NAME (Type) R. Lane Wroth, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county) Easton, Talbot, Md.			22b. DATE SIGNED 1-29-80	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1-30-1980	23c. NAME OF CEMETERY OR CREMATORIAL Spring Hill			23d. LOCATION (City or Town) Easton, Talbot, Md.	(County) (State)
24. FUNERAL DIRECTOR Newnam Funeral Home	ADDRESS Easton, Md.			25a. REC'D BY REGISTRAR FEB 1 1980	25b. REGISTRAR'S SIGNATURE John Wroth	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 357-7818.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 80 02531	
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR									# HOUR 300	
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2b. AGE (IN YEARS AND MONTHS)			2c. # UNDER 1 YEAR	
John			WESLEY			Sinclair			MARCH 14, 1909 70			# UNDER 1 MONTH	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS AND MONTHS)			7. # UNDER 1 DAY	
MALE			WHITE			MARCH 14, 1909			70			YRS	
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH			8b. # UNDER 1 HRS	
MARYLAND			U.S.A.			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			TALBOT			MONTHS DAYS HOURS MIN.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION TYPE OF WORK FOR MOST OF WORKING LIFE			12b. KIND OF BUSINESS OR INDUSTRY			MD	
Easton			Memorial Hospital			WATERMAN			SEAFOOD				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS	
MARYLAND			TALBOT			CLAIBORNE			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			-----	
14. FATHER'S NAME			MIDDLE			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			ADDRESS	
JOHN B. SINCLAIR			LAST			EULA JAMART			217-16-1490A			IRENE M. SINCLAIR CLAIBORNE, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4140 Acute and Chronic Congestive Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ASTH												4 yrs 2 yrs	
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Sepsis 2° to hypo natremia													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 1/19 1980 to 1/19 1980, that (1) (we) last saw the deceased alive on 1/19 1980 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.						1975			1980			19	
22b. SIGNATURE Wm H Wood			22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22d. DATE SIGNED 1/10/80	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Wm H Wood			22f. ADDRESS EASTON, MD										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE JAN. 12, 1980			23c. NAME OF CEMETERY OR CREMATORIAL OLIVET CEMETERY ST. MICHAELS, MARYLAND			23d. LOCATION CITY OR TOWN			TALBOT STATE	
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR JAN 22 1980			25b. REGISTRAR'S SIGNATURE Barry McCready				

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8002532	REG. NO.	
1. FOR STATE REGISTRAR			2. DECEASED NAME FIRST <i>Clementine</i> MIDDLE <i>Smith</i> LAST										2b. DATE OF DEATH <i>Jan. 5 1980</i>	
1c. DECEASED NAME (TYPE OR PRINT)			2c. DATE OF BIRTH MONTH <i>10</i> DAY <i>10</i> YEAR <i>1908</i>										2d. AGE (IN YEARS LAST BIRTHDAY) 72	
3. SEX <i>Female</i>			4. RACE <i>Caucasian</i>			5. DATE OF BIRTH MONTH <i>10</i> DAY <i>10</i> YEAR <i>1908</i>			6. AGE (IN YEARS LAST BIRTHDAY) 72			2e. HOUR 3:55 1 pm		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			7c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			7d. BALTIMORE CITY OR COUNTY OF DEATH <i>Falset</i>			7e. IF UNDER 1 YEAR MONTHS <i>72</i> DAYS <i>0</i>		
7f. IF UNDER 7 HRS HOURS <i>0</i> MIN <i>0</i>			7g. IF UNDER 24 HRS HOURS <i>0</i> MIN <i>0</i>			7h. MD.								
10. CITY OR TOWN OF DEATH <i>Easton</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SAME FACILITY, GIVE STREET ADDRESS) <i>Memorial Hospital</i>										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>	
13a. STATE <i>MD</i>			13b. COUNTY <i>Dorchester</i>			13c. CITY OR TOWN <i>Hurlock</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS <i>N. Main Street</i>		
14. FATHER'S NAME FIRST <i>Alan</i> MIDDLE <i>E.</i> LAST <i>Troup</i>			15. MOTHER'S MAIDEN NAME FIRST <i>Minnie</i> MIDDLE <i>E.</i> LAST <i>Eakin</i>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. <i>218-20-80633</i>			17. INFORMANT ADDRESS <i>William Smith, P.O. Box 216, Hurlock</i>			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 week</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASD with Complete Heart Block</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>1 yr</i>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Retroperitoneal lymphoma</i>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. <i>19</i> MONTH <i>19</i> DAY <i>19</i> YEAR <i>80</i> P.M. <i>19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <i>115</i> CITY OR TOWN <i>Easton</i> COUNTY <i>MD</i> STATE <i>MD</i>								
22a. I certify that (I) (this hospital) attended the deceased from <i>8/1972</i> to <i>1/1980</i> , that (I) (we) last saw the deceased alive on <i>1/1980</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>Wm Atwood</i>			22c. DEGREE <i>MD</i>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <i>1/1/80</i>					
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Wm Atwood</i>			22g. ADDRESS <i>EASTON, MD</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>1-8-80</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Unity Wash. Cem.</i>			23d. LOCATION CITY OR TOWN <i>Hurlock</i> COUNTY <i>Dorchester</i> STATE <i>MD</i>					
24. FUNERAL DIRECTOR NAME <i>Zeller Funeral Home E. New Market</i>			25a. ADDRESS			25b. DATE REC'D. BY REGISTRAR <i>JAN 14 1980</i>			25c. REGISTRAR'S SIGNATURE <i>Victor Schlesinger</i>					

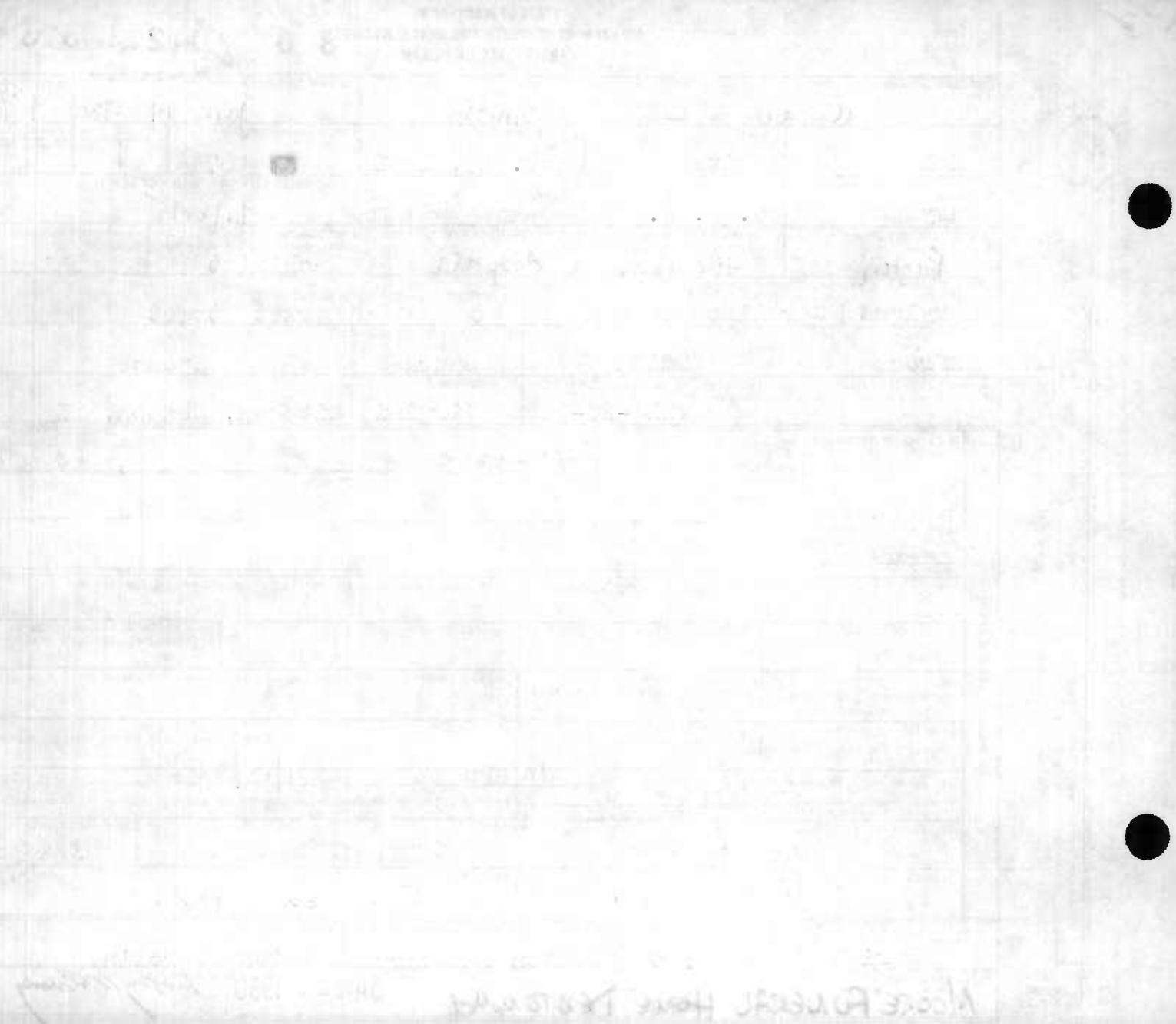
Letter from Mexico to New Haven

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please do not be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8002533		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Oscar L. Smith						Jan. 17 1980						9:30 A.M.		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Male			White			MONTH DAY YEAR Nov. 25, 1892			MONTH DAY			MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS		
Maryland			U. S. A.						Talbot			MONTHS HOURS MIN		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			MD.		
Fenton			the Memorial Hospital			Machinist			Machine					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
Maryland			Caroline			Denton						Market Street		
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST			
Alfred					Smith	Laura					Spence			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
NO			218-20-9280			Virginia Kitchen, Denton, Md								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY												2 days		
IMMEDIATE CAUSE (a) 486 - Pneumonia														
DUE TO, OR AS A CONSEQUENCE OF														
(b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last														
DUE TO, OR AS A CONSEQUENCE OF														
(c) _____														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (I) (he) (she) attended the deceased from 11/4/80 19 to 11/7/80 19, that (I) (he) (she) saw the deceased alive on 11/7/80 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (he) (she) did not view the body after death.														
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			1/18/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			Fenton Rd.								
C.W. BARN														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY STATE		
Burial			1/20/80			Denton Cemetery			Denton			Caroline MD		
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
MOORE FUNERAL HOME DENTON MD						JAN 25 1980			Terry McCreedy					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8002534	REG. NO.
1 - FOR STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR	
George B Tramontana									1-11-80			6:25 p.m.	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
mALE		caucasian		July 6, 1890			89						
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.					
New York		U.S.											
10 CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) teacher			12b KIND OF BUSINESS OR INDUSTRY		
13a STATE Maryland		13b COUNTY Talbot		13c CITY OR TOWN St. Michaels		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS Rio Vista					
14 FATHER'S NAME Nicholas Tramontana					15 MOTHER'S MAIDEN NAME Antoinette (unknown)								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		16c INFORMANT Phyllis Kennedy			17 ADDRESS Demarest, N.J.						
no		144-28-5293											
II CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Primary Embolus</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Alldoloxemis</i>													
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Anticoagulant heart disease</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART II													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE									
22a I certify that (I) (this hospital) attended the deceased from 12-10, 1979, to 1-11, 1980, that (I) (we) last saw the deceased alive on 1-11, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE <i>Edmond J. Fitzgerald</i>		22c DEGREE		22d DATE SIGNED 1-12-80									
ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>									
22e PHYSICIAN'S NAME (TYPE OR PRINT) EDMOND J. FITZGERALD MD		22f ADDRESS 25 CREAMERY LANE, EASTON, MD 21601											
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 1-15-1980		23c NAME OF CEMETERY OR CREMATORIUM Madonna Cemetery		23d LOCATION CITY OF TOWN COUNTY STATE Fort Lee, Bergen, N.J.							
24 FUNERAL DIRECTOR NAME NEWNAM FUNERAL HOME		ADDRESS Easton, Md.		25a DATE REC'D. BY REGISTRAR JAN 16 1980			25b. REGISTRAR'S SIGNATURE <i>Henry Newnam</i>						
DHHM-16 25M (VRA 15, 4) 1/79													

1000

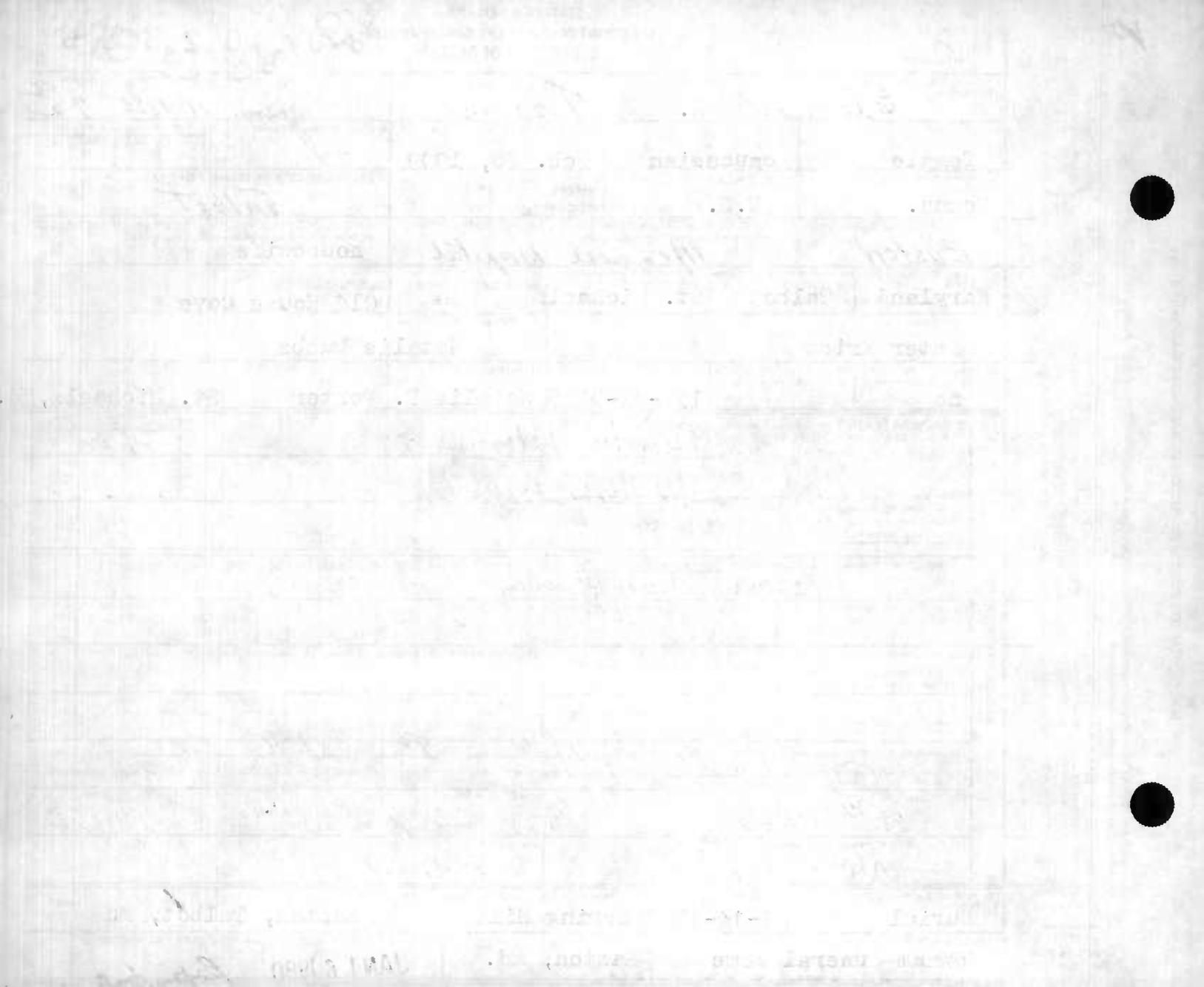
1948

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8002535											
REG. NO.																							
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST Eleanor			MIDDLE K.			LAST Travis			2a. DATE OF DEATH MONTH Feb.			MONTH YEAR 1909			2b. HOUR 50 7 a.m.		
3. SEX female			4. RACE caucasian			5. DATE OF BIRTH MONTH Feb.			DAY 28			YEAR 1909			6. AGE (IN YEARS AT BIRTHDAY) 70			IF UNDER 1 YEAR MONTHS YRS.			IF UNDER 24 HRS MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penns.			7b. CITIZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Talbot			10. CITY OR TOWN OF DEATH Easton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Talbot			13c. CITY OR TOWN St. Michaels			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Old House Cove			14. FATHER'S NAME FIRST Peter Krist			15. MOTHER'S MAIDEN NAME Natalie Dubbs					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO 159-03-0255			17. INFORMANT Natalie T. Porter			18. CAUSE OF DEATH (Enter only one cause per line for 10, 1b, and 1c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 3501 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO, OR AS A CONSEQUENCE OF Diabetic Ketoacidosis Diabetes Mellitus			ADDRESS St. Michaels, Md.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that (I) (this hospital) attended the deceased from 80/10/1980 to 80/10/1980, that (I) (we) last saw the deceased alive on 80/10/1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE Wm. Dubois			22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 1/1/80											
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Wm. Dubois			22f. ADDRESS EASTON, MD			23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial			23b. DATE 1-14-1980			23c. NAME OF CEMETERY OR CREMATORIAL Spring Hill			23d. LOCATION CITY OR TOWN Easton, Talbot, Md.								
24. FUNERAL DIRECTOR NAME Newham Funeral Home			ADDRESS Easton, Md.			25a. DATE REC'D. BY REGISTRAR JAN 16 1980			25b. REGISTRAR'S SIGNATURE Lisa														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then, please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8002536					
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
William O									Whittico			January 27, 1980				100 AM	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			# UNDER 1 YEAR		# UNDER 24 HRS			
Male			Negro			MONTH DAY YEAR			68			YRS.		MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			TALBOT MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Easton			Memorial			Labover											
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS									
MD	86	Centreville			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			104 Little Kinnell									
14. FATHER'S NAME			LAST			15. MOTHER'S MAIDEN NAME											
John			Whittico			Annis											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
YES			11111 219-06-5272			John H						Nov. 1979					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												CARCINOMATOSIS					
1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA COLON					
												DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
November 1979			Carcinoma Colon			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)											
			P.M. 19														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE			
22a. I certify that (I) this hospital attended the deceased from 1/1/80, 19 to 1/27/80, 19, that (I) (we) last saw the deceased alive on 1/26/80, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED								
C. R. BAIN									1/28/80								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			Eoston, Md, 21601.											
C. R. BAIN																	
23a. BURIAL, CREMATION, REMOVAL			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE			
1/31/80			1/31/80			Cheston Field			Centreville			86		MD			
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Henry H. Hall			Easton			FEB 6 1980			Henry H. Hall								

Scorched

Wet sand, very shallow 28 mm

Scorched sand, 6 inches not

shallow. It is not scorched when 28 mm

Scorched sand, 6 inches not

shallow. It is not scorched when 28 mm

Scorched sand, 6 inches not

shallow. It is not scorched when 28 mm

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shallow. It is not scorched when 28 mm

Scorched sand, 6 inches not

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Scorched sand, 6 inches not

shallow. It is not scorched when 28 mm

Scorched sand, 6 inches not

shallow. It is not scorched when 28 mm

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8002537						
1 - STATE REGISTRAR			I. DECEASED NAME			LAST			2a. DATE OF DEATH			2b. HOUR						
(TYPE OR PRINT)			Mary Louise Wiley			Wiley			January 31, 1980			10 52 P.M.						
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR						
Female			White			MONTH DAY YEAR			36			MONTHS DAYS		IF UNDER 24 HRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Rock Hall, Md.			U.S.A.			February 19, 1943			Talbot									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Fenton			The Memorial Hospital			Machine Operator			Solo Cup Co.									
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS									
Maryland			Dorchester			Rhodesdale			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Rt. 1, Box 30						
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS						
FIRST MIDDLE LAST			FIRST MIDDLE LAST			214-32-7926			Mary Belle Smith			Maryland 21659						
18. CAUSE OF DEATH (Enter only one cause per line for part 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY:			19. DUE TO, OR AS A CONSEQUENCE OF			20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
IMMEDIATE CAUSE (a) 4151			1b) Pulmonary embolus															
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause (c)			1c)															
21. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
21a. DATE OF OPERATION			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			21c. AUTOPSY?			21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>									
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21f. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21g. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21h. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21i. PLACE OF INJURY (ATHOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21j. LOCATION STREET			21k. CITY OR TOWN			COUNTY		STATE				
22a. I certify that (1) (this hospital) attended the deceased from 1/22/80 to 1/30/80, that (1) (we) last saw the deceased alive on 1/18/80 at 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.			22b. SIGNATURE William J. Bainfield, M.D.			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED FEB 1 1980									
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS															
William J. Bainfield, M.D.			Easton, Md. 21601															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN			COUNTY		STATE				
Burial			Feb. 3, 1980			Brookview Cemetery			Brookview, Dorchester, Md.									
24. FUNERAL DIRECTOR NAME Frampton-Hawkins F.H. - FEDERALSBURG			ADDRESS Box 43			25a. DATE RECD. BY REGISTRAR FEB 1 1980			25b. REGISTRAR'S SIGNATURE McCreedy									

100% completion of mission

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

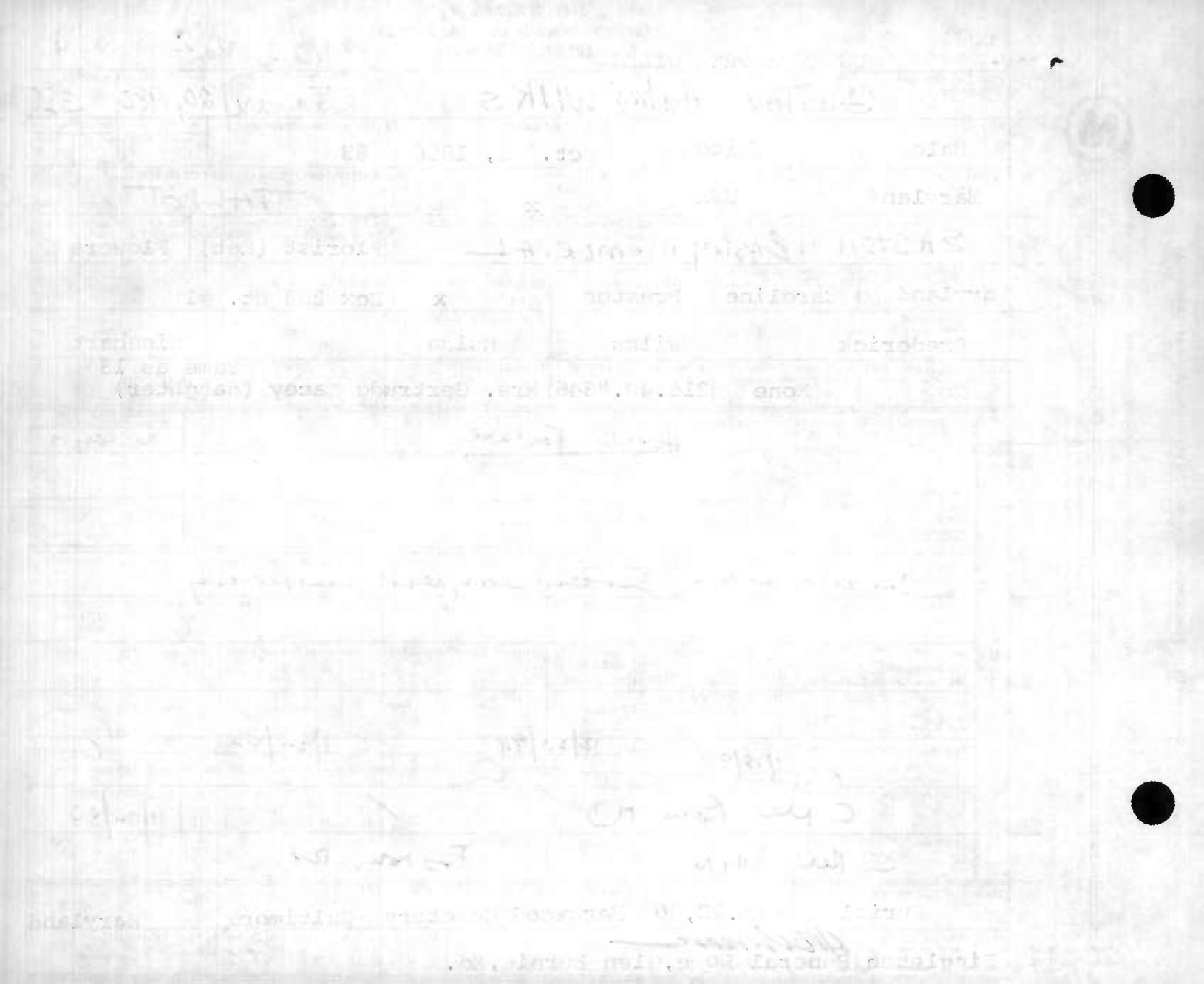
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 02538	REG. NO.			
1 - STATE REGISTRAR			GUSTAV ANDREW WILKS			2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR				
1 DECEASED NAME (TYPE OR PRINT)			Gustav Andrew Wilks			2b DATE OF DEATH			January 20, 1980			3:00 PM				
3 SEX		4 RACE		5 DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS				
Male		White		Month Oct. Day 6, 1896 Year			83			MONTHS	YEARS	MONTHS	HOURS	MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			TALbot						
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
EASTON		EASTON MEMORIAL		Florist (Ret)			Flowers									
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																
13b. STATE Maryland		13b. COUNTY Caroline		13c. CITY OR TOWN Preston			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Box 258 Rt. #1						
14 FATHER'S NAME FIRST Frederick		MIDDLE		15 MOTHER'S MAIDEN NAME LAST Wilks			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO NO		16b. SOCIAL SECURITY NO None		17 INFORMANT Mrs. Gertrude Macey (daughter)			ADDRESS Same as 13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Heart Failure</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>30 days</i>				
4289 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																
DUE TO, OR AS A CONSEQUENCE OF (b)																
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Diabetes mellitus, Diabetic neuropathy, peripheral neuropathy</i>																
19a. MEDICAL CERTIFICATION DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>12/23/79</i> to <i>1/20/80</i> , that (I) (we) last saw the deceased alive on <i>11/18/85</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>C. W. Bain M.D.</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>1/20/80</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>C. W. Bain</i>			22e. ADDRESS <i>Easton, Md.</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan. 22, 80			23c. NAME OF CEMETERY OR CREMATORIAL Parkwood Cemetery			23d. LOCATION CITY OR TOWN Baltimore			COUNTY		STATE Maryland		
24. FUNERAL DIRECTOR NAME <i>W. L. Johnson</i>			ADDRESS Singleton Funeral Home, Glen Burnie, Md.			25a. DATE REC'D. BY REGISTRAR JAN 21 1980			25b. REGISTRAR'S SIGNATURE <i>Henry McElroy</i>							

BP

DHMH-16 25M
(VRA 15, 4) 1/79



ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be witnessed by the hospital or attending physician.

3 **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, **Page 1** and **2** should be detached for use as the burial/transit permit. Then please remove carbon papers. **Pages 1 and 2** should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 0 2 5 3 9
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 40		
Helen T. YAEGER						January 15, 1980			4 AM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
female		caucasian		June 28, 1905			74 yrs.				
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. IF UNDER 24 HRS MONTHS DAYS HOURS MIN	
Penns.		U.S.					Talbot				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Easton		Memorial		housewife							
13a. STATE		13b. COUNTY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
Maryland		Talbot		Easton			131 S. Harrison St.				
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Alfred Taylor		Catherine O'Keefe									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
no		061-07-4058		William F. Culhane Bethesda, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i>									1-5-80		
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral arteriosclerosis</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Uncertain</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
None											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) (this hospital) attended the deceased from 1-5, 1980, to 1-15, 1980, that (1) we last saw the deceased alive on 1-15, 1980, and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (1) we did (did not) view the body after death.											
22b. SIGNATURE Robert W. Trevor, M.D.		22c. DEGREE			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 1-15-80			
22f. PHYSICIAN'S NAME (TYPE OR PRINT) Robert W. Trevor, M.D.		22g. ADDRESS RD 3 Easton Md. 21601									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 19, 1980		23c. NAME OF CEMETERY OR CREMATORIAL Oxford			23d. LOCATION CITY OR TOWN Oxford		COUNTY Talbot		STATE Maryland
24. FUNERAL DIRECTOR NAME Newnam Funeral Home		ADDRESS Easton, Md.			25a. DATE REC'D. FOR REGISTRATION JAN 17 1980			25b. REGISTRATION SIGNATURE Robert W. Trevor, M.D.			

1000 ft. 1000 ft.

000 ft. 1000 ft.